Audit, Risk & Assurance Committee

Thu 01 December 2022, 09:30 - 12:00

Via Microsoft Teams

Agenda

09:30 - 09:40
10 min

1. Preliminary Matters

1.1. Apologies for Absence

Verbal *Chair*

1.2. Declarations of Interest

Verbal *Chair*

1.3. Draft Minutes of the Meeting held on 06 October 2022

Paper *Chair*

1.3 Final Draft ARAC minutes 06.10.2022 .pdf (10 pages)

1.4. Committee Action Log

Paper

1.4 Audit Committee Action Log v3- Dec.pdf (4 pages)

1.5. Committee Annual Programme of Business 2022/23

Paper

1.5 ARA_Committee Work Programme 2022-23_Final.pdf (6 pages)

1.5.1. To Receive an Assurance Note on the status of the Clinical Audit Plan

Paper *Chair*

1.5a Clinical Audit Plan Assurance Note .pdf (2 pages)

09:40 - 10:20
40 min

2. Corporate Governance, Risk and Assurance

2.1. To Receive the Welsh Health Circular (WHC) Tracker including compliance with Ministerial Directions

Paper *Director of Corporate Governance*

2.1 WHC Tracker Cover Report Nov 22.pdf (3 pages)
2.1a WHCs .pdf (4 pages)

2.2. To Receive an Update on the Audit Recommendations Tracker

Verbal *Director of Corporate Governance*

2.2.1. To Receive an Assurance Note on the status of Consultant Job Planning Internal Audit Recommendations

Paper *Director of Corporate Governance*

2.2.1 Consultant Job Planning Internal Audit Reccommendations Assurance Note.pdf (1 pages)
2.2.1a Appendix 1 Action against Consultant Job Planning Internal Audit Reccommendations.pdf (2 pages)

2.3. To Receive the Committee Risk Report

Paper *Head of Risk & Assurance*

2.3 Strategic Risk Report Dec2022docx.pdf (5 pages)
2.3a Corporate Risk Regsiter OverviewNov2022.pdf (11 pages)
2.3b Final Master Risk Profiles Dec2022.pdf (6 pages)

2.4. To Receive an Update on the Risk Management Strategy

Verbal *Director of Corporate Governance*

10:20 - 10:50
30 min

3. Financial Governance and Control

3.1. To Receive the Report of the use of Single Tender Waivers

Paper *Assistant Director of Finance*

3.1 Single Tender Action Report - 01 December 2022.pdf (2 pages)
3.1a Appendix 1 - Oct 2022 to Nov 2022 STA Rep.pdf (1 pages)

3.2. To Receive the Governance Report and Ratify Financial Control Procedures

Paper *Assistant Director of Finance*

3.2 Governance Report -01 December 2022.pdf (6 pages)
3.2a Appendix 1 ABUHB_Finance_0242 FCP Capital Assets and Charges_Final.pdf (17 pages)
3.2b Appendix 2 - Financial Control Procedures St.pdf (1 pages)

3.3. To Receive a Progress Report on Asset Verification

Paper *Interim Assistant Finance Director - Financial Strategy, Planning*

Suzanne Jones, Interim Assistant Finance Director - Financial Strategy, Planning will be attending to present the report

3.3 Asset Verification Update November 2022 .pdf (6 pages)

10:50 - 11:00
10 min

4. Anti-Fraud

4.1. To Receive a Quarterly Report on Counter Fraud Activity

Paper *Head of Counter Fraud*

4.1 Counter Fraud Audit Committee report 1 December 2022.pdf (6 pages)

11:00 - 11:25
25 min

5. Internal Audit (Including Specialised Audit) – NWSSP Audit & Assurance Services

5.1. To receive the Internal Audit Plan Progress Report

Paper *Head of Internal Audit and Director of Audit & Assurance, NHS Wales SSP*

5.1 AB Internal Audit and Assurance Progress Report December 2022 ARA Committee v3.pdf (8 pages)

5.2. To receive the Internal Audit Reports

5.2.1. Reasonable/Substantial Assurance & Advisory Reports

Paper *Head of Internal Audit and Director of Audit & Assurance, NHS Wales SSP*

- Benefits of Digital Solutions
- Decarbonisation (Advisory)

5.2a AB 2223-21 Digital Benefits Realisation Final Internal Audit Report for Client.pdf (13 pages)
5.2b Final All-Wales Decarbonisation Report ABUHB.pdf (15 pages)

5.2.2. Limited Assurance

Paper *Head of Internal Audit and Director of Audit & Assurance, NHS Wales SSP*

- Clinical Audit Plan

Dr James Calvert, Medical Director and Leeanne Lewis, Assistant Director for Patient Quality & Safety will be attending to address questions raised by Members

5.2d AB 2223-05 Clinical Audit Final Internal Audit Report.pdf (18 pages)

11:25 - 11:45
20 min

6. External Audit

6.1. To receive the External Audit Progress Report 2022-23

Paper *Performance Audit Manager, Audit Wales*

6.1 Audit Risk & Assurance Committee Update_Dec 2022.pdf (10 pages)

6.2. To Receive the Final Annual Accounts Memorandum

Paper *Finance Audit Manager, Audit Wales*

6.2 Audit_of_accounts_report_addendum_21-22_abuhb_final.pdf (16 pages)

11:45 - 11:50
5 min

7. For Information

Verbal *Chair*

7.1. PRESS RELEASE: £6.5 million of fraud and overpayments identified by National Fraud Initiative in Wales

Paper

7.1 The_National_Fraud_Initiative_in_Wales_2020_21_English_0.pdf (25 pages)

7.2. Making Equality Impact Assessments more than just a tick box exercise

Paper

7.2 Equality_impact_assessment-english_0.pdf (44 pages)

7.3. Internal Audit Management Response Guide

Paper

7.3 Internal Audit Management Responses Guide.pdf (2 pages)

11:50 - 12:00
10 min

8. Close Of Meeting

Verbal *Chair*

Date of Next Meeting:

02 February 2023: 09:30 – 12:00

Pre Meet: Internal Audit: 09:00 - 09:30

In Committee: 12:00 - 13:00

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

Minutes of the Audit, Risk & Assurance Committee held on Thursday 6th August 2022 at 9.30 am via Teams

Present:	
Iwan Jones (Chair)	Independent Member (Finance)
Paul Deneen	Independent Member (Community)
Katija Dew	Independent Member (Third Sector)
Shelley Bosson	Independent Member (Community)
In attendance:	
Rani Mallison	Director of Corporate Governance
Rob Holcombe	Interim Director of Finance, Procurement & Value
Mark Ross	Assistant Finance Director (Corporate)
Danielle O'Leary	Head of Corporate Services, Risk and Assurance
Simon Cookson	Head of Internal Audit, NWSSP
Stephen Chaney	Deputy Head of Internal Audit, NWSSP
Nathan Couch	Performance Audit Lead, Audit Wales
Tracey Veale	Finance Audit Lead, Audit Wales
Apologies:	
Andrew Doughton	Performance Audit Manager, Audit Wales
Richard Clarke	Independent Member (Vice Chair)
Richard Harries	Audit Wales

	Preliminary Matters
AC 0610/01	**Apologies for Absence** The Chair welcomed everyone to the meeting. Apologies for absence were noted.
AC 0610/02	**Declarations of Interest** There were no Declarations of Interest to record.
AC 0610/03	**Draft Minutes of the Meeting held on 02 August 2022** The Committee accepted the minutes as a true and accurate reflection of the meeting.
AC 0610/04	**Action Sheet** The Committee reviewed the Action Sheet and approved the removal of completed actions as it was satisfied that all completed actions had been sufficiently completed. The following amendment to actions were requested • Action AC 0208/13 amend the target date to 01 Dec '22 • Include an action item from the 02 August '22 meeting for the Medical Director to attend to provide an update on Job Planning. **Action: Secretariat**
AC 0610/05	**Committee Annual Programme of Business 2022/23** The Committee was encouraged to see the document progressing into an intuitive document that provided members with the necessary assurance that the Committee was carrying out its responsibilities as outlined in the Committee Terms of Reference (ToR). In relation to additional items, the Interim Director of Finance (IDofF) requested clarification on the purpose of the Decarbonisation Update report. The DofCG would confirm when a decarbonisation item was scheduled for the Partnerships, Population Health & Planning as the appropriate assurance committee. **Action: Director of Corporate Governance** The Committee; - • NOTED the Committee Annual Programme of Business 2022/23 report.
	Assurance Note explaining the postponement of the Clinical Audit Plan A request to postpone the presentation of the Clinical Audit Plan was received and approved (until the Committee's next meeting on December 01, 2022)

	Corporate Governance, Risk and Assurance
AC 0610/06	**Internal & External Audit Recommendation Tracker** The Committee received an update on the status of implementing internal and external audit recommendations since the Tracker was last presented to the Committee in August 2022. The current position reported was that there were 73 internal audit actions overdue, 16 high, 25 medium, 17 low, and 15 not rated, and nine external audit actions overdue, 6 high, two medium, and one not rated, for the period between 2017 and 2021. The Committee was asked to consider the revision of nine (9) overdue recommendations and approve revised timeframes for both internal and external audits to the original agreed-upon implementation dates. The Committee agreed that the recommendations that predated 2021-22 required a focused review to determine whether they were still relevant in the current operating environment. The DofCG agreed to work with respective directors to review the 35 Internal/External recommendations pre 2020/21, as well as the high recommendations issued in 2021/22, ensuring revised timescales are confirmed for each. **Action: Director of Corporate Governance** Shelly Bosson (SB), Independent Member, requested that the closed status for the Job Planning recommendations be reopened because the update against the recommendations did not provide assurance that the actions taken were sufficient to close it. The DofCG agreed to reopen the audit recommendations and bring a clarified position to the next meeting to ensure that sufficient assurance could be taken on their completion/closure. **Action: Director of Corporate Governance** In addition, a People and Culture Committee assurance report had been scheduled for January, as had a medical workforce briefing session with the Board, with a focus on job planning. The Committee; - • NOTED the position in respect of overdue audit recommendations; and • APPROVED the proposed revised dates for implementation in respect of several audit recommendations

Committee Risk Report (CRR)
The report was delivered by the Head of Risk and Assurance (HofR&A), who outlined the key points and provided updates on the principal risks.

The Committee was informed that the Health Board was now reporting 25 organisational risk profiles as a result of the Finance and Performance Committee de-escalating risk CRR020 WCCIS to a divisional risk.

As a result of CRR020's de-escalation, the HofR&A advised that there were three risks on the Corporate Risk Register, listed below, that were actively managed within an approved and agreed risk appetite/tolerance level.

- CRR023 – Avoidable harm to the population
- CRR004 – WbFGA and Socio-Economic Duty
- CRR008 – Health Board estate being fit for purpose

The Committee noted that the CRR016 Financial Breakeven 2022/23 risk remained at its previous score, but the trajectory for this position continues to escalate. Members were informed that a clear management plan was in place and that the Finance and Performance Committee was monitoring the position and would escalate to the Audit, Risk, and Assurance Committee if necessary.

The Committee expressed concern about CRR016 because the mid-year finance report was due to the Welsh Government on Thursday, October 13th. The IDofF informed members that the Board had received detailed analysis of what is driving the Health Board's forecast, and that a Board Development session scheduled for Wednesday, October 12th would provide an opportunity for the Board to be appraised on how the forecast was established, as well as an opportunity to discuss the management plan.

The Committee was informed that the position at the end of month 6 was likely to be a deficit. The Chief Executive Officer (CEO) would issue an Accountable Officer letter outlining the issues affecting the Health Board's position. To provide some reassurance to the Committee, the IDofF advised that ABUHB was not an outlier in comparison to other Health Boards, and that four (4) other Health Boards across Wales would be reporting deficits.

The Committee; -

- NOTED the updated position to the Committee Risk Report
- NOTED the update to the Benefits Realisation Plan associated with the Risk Management Strategy

	Financial Governance and Control
AC 0610/09	**Use of Single Tender Waivers** The Assistant Finance Director (AFD) provided an update on the use of Single Tender Waivers. Since the last report to the Committee in August, three (3) requests had been submitted and approved, with an annual value of £120,579.63 ex VAT. All 3 were classified as licencing or maintenance/service type arrangements. The Committee; - • APPROVED the Use of Single Tender Waivers report.
AC 0610/10	**Governance Report and Ratification of Financial Control Procedures (FCPs)** The AFD presented the Governance Report to the Committee and requested approval of two (2) Financial Control Procedures noting that the document changes were primarily for clarification, updates to Welsh Government guidance, and organisational responsibility. The Losses & Special Payments FCP details how payments are approved, accounted for, and reported within the organisation, as well as the delegation limits for losses and special payments. The Stocks & Stores FCP provides detailed guidance and direction for those employees with direct responsibility for the requisitioning and issuing of stores and stock items to mitigate the risk of loss or potential fraud within the Health Board The Committee requested that section *8.7 Stocktaking* in the Stocks & Stores FCP be reworded to make it clear that perpetual inventory systems should be used where they are available**.** **Action: Assistant Director of Finance** The Committee noted that the Health Board's public sector payment target had retuned to 95% compliance. The Committee: - • NOTED the Governance Report • APPROVED the Losses & Special Payments and Stocks & Stores Financial Control Procedures
AC 0610/11	**Losses and Special Payments Report** The AFD presented the Losses and Special Payments Report, which covered the period from April 1st to July 31st, 2022. The key issues highlighted were as follows; - • Losses and special payments recorded during the period 1st April 2022 to 31st July 2022 totalled £11.0m of which £9.7m was

	recoverable from the Welsh Risk Pool (WRP), resulting in a £1.3m loss for the Health Board. • Provision for clinical negligence and personal injury cases had decreased by £7.3m since 31st March 2022 to an overall provision of £180.5m, of which £174.7m was expected to be recoverable from WRP, leaving a potential future loss to the Health Board of £5.8m. It was suggested that the wording regarding the provision for clinical negligence and personal injury cases be reframed to provide reassurance that the £5.8m is provided for and included in financial projections. **Action**: **Assistant Finance Director** The Committee was informed of an input error in the Financial Analysis of Losses table regarding loss of personal effects; the actual loss was £5k, with an additional £5k being a payment to the Ombudsman that should have been reported in 'Other.' The AFD would ensure that this was corrected in future iterations of the report. **Action: Assistant Finance Director** The Committee inquired whether the Health Board conducts loss trend analysis. The AFD stated that this is not currently being done, but a comparison table comparing year on year data could be included. He also reassured members that the Litigation Committee would be the forum for identifying trends and learning lessons in clinical negligence and personal injury claims. The DofCG provided additional reassurance, stating that there were clear assurance arrangements in place through the Patient Quality, Safety and Outcomes Committee (PQSOC), but that there was potential to strengthen those arrangements. The Health Board's provision for clinical negligence and personal injury claims liability was clarified. The Committee was reassured that processes and arrangements were in place to manage the Health Board's provision and stability, and that financial forecasts are based on the current situation. The Committee; - • NOTED the Losses and Special Payments Report
AC 028/12	**Financial Accountability Arrangements Summary Report** The Committee received the report, noting that the purpose of the report was to provide assurance that the organisation has established control procedures in place to manage delegated budgets. The report outlined the key areas of the Health Boards' Standing Orders (SOs), Standing Financial Instructions (SFIs), and Financial Control Procedures (FCPs), which identified how budgetary control,

	expenditure control, and the tier system of control for delegated authority operate. The IDofF informed the Committee that the Executives had implemented delegated authority within their areas of responsibility, however budget holders were not identifying mitigating actions early enough to restore financial balance. The Committee was confident that the Budgetary Control FCP clearly laid out the process, but given the IDofF's comments, it had reservations about the application and adherence to the procedure. The Committee; - • NOTED the Financial Accountability Arrangements Summary Report.
	NWSSP Audit and Assurance – Internal Audit and Specialist Service Unit
AC 0610/13	**Internal Audit Plan Progress Update** The Head of Internal Audit (HofIA) informed the Committee that 29 audits were scheduled for 2022/23, with two (2) from 2021/22. The position of the 2022/23 Audit Plan against progress was six (6) in draft/final, seven (7) in progress, and nine (9) in the planning stage. It was noted that a significant number of reports would be received for the December meeting, including three audits that had been delayed over the summer, as follows; - • Clinical Audit • Neighbourhood Care Networks (NCNs)/ Access to Primary Care • Use of off-contract Agency • Quality Framework • Discharge Planning • Benefits of Digital Solutions • IT Strategy • Decarbonisation The Committee was informed that while the Children and Young People's Continuing Care audit began as an advisory review, there was enough evidence to conclude the review as an assurance output due to a significant volume of testing. In relation to the Decarbonisation Audit, it was advised that field work on 5 NHS organisations discovered that implementation plans had not been sufficiently developed to allow for meaningful testing and to provide an assurance rating, so a summary report of key findings and issues would be shared with organisations in due course prior to the rescheduled Audit in late December or early January. Prior to the full Audit, organisations that were not part of the fieldwork, such as

	ABUHB, would receive a separate appendix detailing the specific recommendations for implementation. The Committee noted that during the planning phase of the Infection, Prevention, and Control (IP&C) Audit, a request was made to delay fieldwork until quarter four due to current pressures on clinical nursing staff. Deferring the audit, would not increase the inherent risk. The HofIA proposed that the Governance Audit be brought forward to avoid disruption and to ensure that the IP&C audit could be included in the annual opinion. The approach was supported by the Committee and the DofCG. The Committee; - • NOTED the progress of the 2022/23 Internal Audit Plan • NOTED the change of the children's community nursing service – children and young people continuing care from an advisory review to an assurance review • Approved the change from an assurance to an advisory review for the decarbonisation audit • APPROVED the changes to the Audit Plan
AC 0610/13	**Internal Audit Reviews** The Committee received the following Internal Audit Assurance reports and advisory reviews; - • Job Evaluation Process *(reasonable assurance)* • Children and Young People's Continuing Care *(reasonable assurance)* • Integrated Audit Plans – GUH *(substantial assurance)* • Agile Delivery *(advisory review)* To reassure the Committee that the Children and Young People's Continuing Care Report would be disseminated through the management and governance system, the DofCG would ensure that the recommendations were highlighted when the item was presented to the next QPSOC meeting. Furthermore, regarding the staff survey results and training aspects, the report would be shared with the Director of Workforce & OD as additional intelligence for a training discussion at the People & Culture Committee. **Action: Director of Corporate Governance** The Committee: - • NOTED the Internal Audit Assurance reports and the Advisory Review
	External Audit
AC 0610/14	**Performance Update Report** The Performance Audit Lead (PAL), Audit Wales, presented the Performance Update report noting:

- completed work,
- work that had begun,
- and planned work that had not yet begun.

The Committee noted that a joint post-project learning (PPL) session between Finance and the audit team would be held in late October to reflect on the 2021-22 audit and to implement agreed-upon actions to further improve next year's closedown and audit experience. Following the PPL session, a draft Audit of Accounts Addendum Report would be submitted to management for approval before being presented to the Committee.

The Committee was informed that due to the priority given to auditing the statutory accounts of local government bodies, the audit work for the Health Boards Charitable Funds 2021-22 financial statements would not take place until January 2023, resulting in the Health Board Charity being listed as not having met the 31st January deadline.

The Committee was concerned to learn that the Health Board would be listed as having missed the deadline, even though the Health Board had prepared the accounts for audit in July. The Committee requested that Audit Wales obtain a confirmed date for when the audit work could begin, after which the Health Board would consider potential dates to reschedule the Charitable Funds Committee set for January 5th, 2023.
Action: Finance Audit Lead / Secretariat

The IDofF suggested that a request be made to the Auditor General for resources to be transferred from the performance audit work to the governance audit work. The DofCG advised that should Audit Wales be unable to complete the audit in time for the Health Board to submit its audited charitable fund accounts, a discussion would need to be take place with the Chair and Chief Executive Officer so that appropriate decisions could be taken on next steps. It was noted that this would be decision for the Board as the Trustee of the fund. If required, the DofCG would facilitate the discussion.
Action: Director of Corporate Governance

Exhibit 4: Planned work that has not yet been started or revised; the locally focused work would be a follow-up review of primary care services. The audit would be carried out across all Health Boards. It was noted that ABUHB had been contacted, and the executive lead had been identified. In October, a project brief and self-assessment would be issued to Health Boards.

The Committee; -
- NOTED the Performance Update report.

AC 0610/18	The Committee NOTED the following for information; - • Audit Wales - Public Sector Readiness for Net Zero Carbon by 2030: Evidence Report • Audit Wales - Continued COVID-19 response alongside growing patient demand keeps NHS funding growing as three health boards breach financial duties again • Audit Wales – Consultation on Fee Scales 2023 /2024
AC 0610/23	**Date of Next Meeting** The date of the next business meeting was noted as: - Thursday 1st December 09:30 -12:30 via Microsoft Teams.

Audit, Risk & Assurance Committee
Action Sheet

All actions in this log are currently active and are either part of the Committee's forward work programme or require an update against the action.

Once the Committee is assured that an action is complete, it will be removed. This will be agreed at each Committee meeting.

KEY	
D of CG	Director of Corporate Governance
D of FP&V	Director of Finance, Procurement and Value
AD of F	Assistant Director of Finance
H of CF	Head of Counter Fraud
H of R&A	Head of Risk & Assurance
H of IA	Head of Internal Audit
DH of IA	Deputy Head of Internal Audit
PAM AW	Performance Audit Manager, Audit Wales

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
August 2022	**AC 0208/06**	For assurance, an update on the progress of Medical Job Planning to be provided at a future meeting.	Secretariat	**01 Dec '22**	**In progress.** A substative update on Job Planning scheduled for the People & Culture Committee in January 2022. Report to be shared with ARA Committee members, when available.
August 2022	**AC 0208/08** Committee Risk Report (CRR)	Risk CR0027 - Discuss with the Executive Lead whether broadening the current risk to include seasonal vaccinations and having an overarching immunisation risk is appropriate.	H of R& A Director of Public Health and Strategic Partnerships	**06 Oct '22**	**Completed.** The Director of Public Health has agreed that the vaccination / immunisation risk should be amalgamated. This will be reflected in the November 2022 Strategic Risk Report to the Board.
August 2022	**AC 0208/13** Internal Audit Reviews	Develop a criterion to aid management in completing comprehensive management responses	D of CG DH of IA	**1st Dec '22**	**Completed.** On the agenda for information.
October 2022	**AC 0610/05** Committee Annual Programme of Business 2022/23	Confirm with the IDofF when a decarbonisation item is scheduled for the Partnerships, Population Health & Planning Committee (PPH&P).	D of CG	**31 Dec '22**	**Completed.** An update is scheduled for the next PPH&P Committee in April, 2023.

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

October 2022	**AC 0610/06** Internal & External Audit Recommendation Tracker	Work with respective directors to review the 35 Internal/External recommendations pre 2020/21, as well as the high recommendations issued in 2021/22, ensuring revised timescales are confirmed for each.	D of C G	**01 Dec '22**	**Completed.** To be included in the substantive agenda item.
October 2022	**AC 0610/06** Internal & External Audit Recommendation Tracker	Reopen audit recommendations arising from the Internal Audit review of Job Planning , ensuring that sufficient assurance can be taken on their completion/closure.	D of C G	**01 Dec '22**	**Completed.** An assurance note has been developed by DoWOD and Medical Director and included as part of item 2.2.
October 2022	**AC 0610/10** Governance Report and Ratification of Financial Control Procedures (FCPs)	Reword section 8.7 Stocktaking in the Stocks & Stores FCP so it is clear that perpetual inventory systems should be used where they are available**.**	AFD	**14 Oct '22**	**Completed** FCP amended and published to SharePoint.
October 2022	**AC 0610/11** Losses and Special Payments Report	Reframe the narrative regarding the provision for clinical negligence and personal injury cases to provide reassurance that the £5.8m is provided for and included in financial projections.	AFD	**01 Dec '22**	**Completed** The narrative has been reframed and included in the next iteration of the report.
October 2022	**AC 0610/11** Losses and Special Payments Report	Correct the input error in the Financial Analysis of Losses table regarding loss of personal effects.	AFD	**01 Dec '22**	**Completed** Corrected.

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

October 2022	**AC 0610/13** Internal Audit Reviews	Share the Children and Young People's Continuing Care report with the Director of Workforce & OD as additional intelligence in respect of wider work on staff wellbeing and experience.	D of C G	**14 Oct '22**	**Completed** Shared via email with the Director of Workforce & OD.
October 2022	**AC 0610/14** External Audit Performance Update Report	Confirm a date for the audit of the Charitable Funds Accounts to begin.	*Audit Wales Finance Audit Lead	**31 Oct '22**	**Completed.** Audit started 14th November 2022
October 2022	**AC 0610/14** External Audit Performance Update Report	A discussion regarding next steps would need to take place with the Chair and Chief Executive Officer should Audit Wales be unable to complete the audit in time for the Health Board to submit its audited charitable fund accounts. * This action is dependent on the outcome of the Finance Audit Lead's action.	D of C G		**Removed.** Confirmation that the audit of the Charitable Funds Accounts had begun on November 14th rendered this action obsolete.

AUDIT, RISK & ASSURANCE COMMITTEE
PROGRAMME OF BUSINESS 2022/23

The purpose of the Audit, Risk and Assurance Committee is to support the Board and Accountable Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report.

This Annual Programme of Business has been developed with due regard to guidance set out in NHS Wales' Audit Committee Handbook (June 2012), to enable the Audit, Risk and Assurance Committee to: -

- fulfil its Terms of Reference as agreed by the Board (March 2022);
- seek assurance and provide scrutiny on behalf of the Board, in relation to the delivery of the key elements of the health boards internal and external audit, counter fraud and PPV arrangements (second and third lines of defence);
- seek assurance that governance, risk and assurance arrangements are in place and working well;
- seek assurance in relation to the preparation and audit of the Annual Accounts; and
- ensure compliance with key statutory, national, and best practice audit and assurance requirements and reporting arrangements.

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			7th April	17th May	13th June	2nd Aug	6th Oct	1st Dec	2nd Feb
Preliminary Matters									
Attendance and Apologies	Standing Item	Chair	√	√	√	√	√	√	√
Declarations of Interest		All Members	√	√	√	√	√	√	√
Minutes of the Previous Meeting		Chair	√	√	√	√	√	√	√
Action Log and Matters Arising		Chair	√	√	√	√	√	√	√
Committee Requirements as set out in Standing Orders									
Development of Committee Annual Programme of Business 2022/23	Annually	Chair & Director of CG				√			
Review of Committee Programme of Business	Standing Item	Chair					√	√	√
Annual Review of Committee Terms of Reference 2022/23	Annually **(April)**	Chair & Director of CG							
Annual Review of Committee Effectiveness 2022/23	Annually **(April)**	Chair & Director of CG							
Committee Annual Report 2022/23	Annually **(April)**	Chair & Director of CG							
Corporate Governance, Risk & Assurance									
Receive assurance on implementation of the Governance Priorities set out within the IMTP 2022-25	Quarterly	Director of CG					x	x	Request to reschedule
Review and report upon the adequacy of arrangements for declaring, registering and handling interests	Annually	Director of CG						x	Request to reschedule
Receive full report of all offers of gifts and hospitality as declared	Annually	Director of CG						x	Request to reschedule
Compliance with Ministerial Directions	Bi-Annually	Director of CG			√		x	Rescheduled √	
Compliance with Welsh Health Circulars (WHCs)	Bi-Annually	Director of CG			√		x	Rescheduled √	
Review of Standing Orders, Standing Financial Instructions and Scheme of Delegation	Annually	Director of CG							√

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			7th April	17th May	13th June	2nd Aug	6th Oct	1st Dec	2nd Feb
Review of Audit Recommendation Tracking Procedure	Annually	Director of CG	√						
Audit Recommendations Tracking Report	Standing Item	Director of CG	√			√	√	√	√
Annual Review of Risk Management Strategy	Annually	Director of CG					x	Rescheduled √	
Report on the Implementation of the Risk Management Strategy Realisation Plan	Bi-Annually	Director of CG					√		
Annual Review of the Board Assurance Framework Process	Annually	Director of CG							√
Review of the Board Assurance Framework	Bi-Annually	Director of CG				√			
Committee Risk Report	Standing Item	Director of CG	√			√	√	√	√
Financial Governance and Control									
Report of the use of Single Tender Waivers	Standing Item	Director of FPV	√	√		√	√	√	√
Report of Losses and Special Payments	Bi-Annually	Director of FPV		√			√		
Reviewed and Updated Financial Control Procedures	As Required	Director of FPV	√			√			
Annual Report and Accounts									
To consider the approach and timelines for the Annual Report and Accounts	Annually	Director of FPV & Director of CG	√						
Review the Health Board's Annual Report (Overview & Performance Section) (Part 1)	Annually	Director of CG		√	√				
Review Draft/Final Accountability Report, including Annual Governance Statement (Part 2)	Annually	Director of CG		√	√				
Review Draft/Final Annual Accounts and Financial Statements (Part 3)	Annually	Director of FPV		√	√				
Audit Enquiries to those charged with Governance and Management	Annually	Director of FPV		√					
Audit Wales, Audit of Accounts (ISA 260) including Letter of Representation	Annually	External Audit			√				
Final Annual Accounts Memorandum	Annually	External Audit						√	
Receive the Annual Head of Internal Audit Opinion (including Specialised)	Annually	Internal Audit			√				
Agree a recommendation to the Board in respect of the audited annual report and accounts	Annually	Chair			√				

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			7th April	17th May	13th June	2nd Aug	6th Oct	1st Dec	2nd Feb
Anti-Fraud									
Review of the Counter Fraud, Bribery and Corruption Policy	3-Yearly (2023)	Director of FPV							
Receive the Counter Fraud Annual Report	Annually	Head of CF		√					
Agree the Counter Fraud Annual Workplan	Annually	Head of CF		√					
Receive a Quarterly Report on Counter Fraud Activity	Quarterly	Head of CF				√		√	
Agree the Counter Fraud Functional Standard Return Declaration	Annually	Head of CF			√				
Receive the Post Payment Verification Annual Report	Annually	PPV Manager				√			
Agree the Post Payment Verification Annual Workplan	Annually	PPV Manager							
Receive a Mid-Year update in respect of Post-Payment Verification Activity	Bi-Annually	PPV Manager							
Clinical Audit									
Ratify the Clinical Audit Plan to be overseen by the PQSO Committee	Annually	Medical Director					X	X	Request to reschedule
Receive an Annual Report on Clinical Audit Activity	Annually	Medical Director							√
Internal Audit (Including Specialised Audit) – NWSSP Audit & Assurance Services									
Agree the Internal Audit Annual Workplan	Annually	Head of Internal Audit			√				
Receive Internal Audit Progress Reports	Standing Item	Head of Internal Audit	√	√	√	√	√	√	√
Receive Internal Audit Review Reports, reviewing the adequacy of executive & management responses to any issues identified, ensuring that they are acted upon	As Scheduled within Annual Work plan	Head of Internal Audit Plan							
Review and approve Internal Audit terms of reference (charter) and the effectiveness of internal audit	Annually	Head of Internal Audit with Chair			√				
External Audit – Audit Wales									
Receive the External Audit Annual Audit Report	Annually	Audit Wales						x	Request to reschedule
Agree the External Audit Annual Plan	Annually	Audit Wales		√					√

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			7th April	17th May	13th June	2nd Aug	6th Oct	1st Dec	2nd Feb
Receive the 2022 Structured Assessment	Annually	Audit Wales						x	Request to be rescheduled √
Receive External Audit Progress Report 2022-23	Standing Item	Audit Wales	√	√		√	√	√	√
Review of External Audit Reports including results & the adequacy of executive & management responses to any issues identified, ensuring that they are acted upon	As Scheduled within Annual Work plan	Audit Wales							
Consider any Audit Wales National Value for Money Examinations & Performance Reports	Ad-hoc	Audit Wales							
Audit, Risk and Assurance Committee Members to meet Independently with:									
External Audit Team	Bi-Annually	Chair					√		
Internal Audit Team	Bi-Annually	Chair				√			√
Local Counter Fraud Team	Bi-Annually	Chair	√					√	

KEY	
D of CG	Director of Corporate Governance
D of FPV	Director of Finance, Procurement and Value
Head of CF	Head of Counter Fraud
PPV	Post Payment Verification

KEY	
√	Received at the scheduled meeting
X	Not received at scheduled meeting
Rescheduled √	Committee agreed
Request to Reschedule	Request to the Chair/Committee
	Draft & Final Accounts
	Next scheduled meeting

Aneurin Bevan University Health Board

Health Board Committee Assurance Note

Deferred Item	Clinical Audit Plan
Date scheduled on Forward Work Programme	6th October 2022
Proposed Date for deferment	03 February 2023
Executive Lead	Dr James Calvert, Medical Director Jenny Winslade, Executive Director of Nursing
Reporting to:	Audit, Risk & Assurance Committee

Summary

We would like to extend our apologies to the ARA Committee for the delayed submission of the Clinical Audit Plan.

The postponement has been requested as a result of both a new Director of Nursing, who has recently joined, and a new Assistant Director for Quality and Patient Safety, who commenced in October 2022 being key to the preparation of the Plan.

The Director of Nursing and the Medical Director hold joint responsibility for clinical audit and resulting quality and patient safety issues. The process is managed operationally by the newly appointed Assistant Director of Quality & Patient Safety and the Assistant Director of Nursing.

The clinical audit plan has been fully drafted and discussions have taken place between the Medical Director, the Director of Nursing, Assistant Director of Nursing and Assistant Director for Quality and Patient Safety, and a number of actions have resulted. One of which is the requirement to undertake a Quality Assurance Day with Exec Leads, Quality Patient Safety, Nursing, Therapies, Risk and Governance and Quality Improvement. An away day has been arranged for December and this will aim to set out the framework for a comprehensive Quality Strategy for the organisation through which we will define our ambitions for quality improvement, be clear on quality assurance and governance functions and will set out the form of the groups that will be charged with delivery of the assurance. This away day will also set out the parameters for Quality and Safety reporting including a dashboard and reporting requirements. The meeting will allow a robust structure for reporting risks, route of escalation and the mechanism for providing assurance around the Clinical Audit Plan to be defined. It will also ensure that the plan fits into the wider quality and safety assurance framework.

Once the Quality Governance Day has taken place and the Quality Strategy is finalised with its associated assurance and governance framework, we will ensure any actions in the Clinical Audit Plan are implemented immediately. This will enable any amendments to be made with time to submit the paper to the February 2023 committee.

We do not believe there are any performance, safety or reputational implications to the paper coming to the committee at a later date given that clinical audit needs to be set within the context for Quality in its broadest sense which the new Strategy will deliver.

GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit, Risk and Assurance Committee 1st December 2022 Agenda Item: 2.1

Aneurin Bevan University Health Board

Welsh Health Circular Tracking

Purpose

The paper presents the Audit, Risk and Assurance Committee with an overview of the current position relating to the implementation of Welsh Health Circulars (WHC) within Aneurin Bevan University Health Board.

The Committee is asked to:	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	✓
Note the Report for Information Only	

Executive Sponsor: Rani Mallison, Director of Corporate Governance

Report Author: Bryony Codd, Head of Corporate Governance

Report Received consideration and supported by:

Executive Team		**Committee of the Board**	N/A

Date of the Report: 21st November 2022

Supplementary Papers Attached:

- **Appendix A** – Master Welsh Health Circular Tracker

Detailed Assessment

Welsh Health Circulars

A Welsh Health Circular (WHC) is health guidance, issued by Welsh Government to NHS Wales health bodies and professionals as a circular. Whilst issued as guidance, WHCs will often include expected actions to be implemented by respective organisations and individuals. The publication of WHCs can be seen at Health circulars | GOV.WALES.

For Aneurin Bevan University Health Board, WHCs are received from Welsh Government and issued via the Corporate Governance Team for action to the respective director leads/professional groups. Progress against implementation has been published in the Annual Governance Statement for the past 2 years. However, to ensure a more robust process is in place to monitor the status of WHCs throughout the year, a WHC Tracker has been established. Progress against the tracker will be reported to the Audit, Risk and Assurance Committee twice a year.

The Annual Governance Statement 2021/22 confirmed that those WHCs issued during 2021/22 had been implemented. The Tracker therefore captures WHCs issued since 1st January 2022.

For 2022/23, there are currently 22 WHCs included within the tracker, as issued by Welsh Government. An overview of progress is provided below:

	2022
	Position at 21/11/2022
No Progress	0
In Progress	6
Complete	16
Total Number issued	**22**

Ministerial Directions

The current position in relation to compliance with Ministerial Directions is as reported in the Annual Governance Statement 2021/22 (Attachment B). The Health Board is not aware of further Ministerial Directions issued. Work is ongoing with the Welsh Government and Deputy Board Secretaries group to establish a clear process on where and how Ministerial Directions are issued throughout the year in order to gather information and monitor progress through the year. These will then be included within the tracking tool as soon as possible.

Next Steps

The Corporate Governance Team will continue to log and distribute Welsh Health Circulars for action as and when they are received. An updated position will be presented to the Committee in March 2023.

Recommendation

The Audit, Risk & Assurance Committee is asked to:

- NOTE the report and;
- Discuss the current position.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The coordination and reporting of the implementation of WHCs are key elements of the Health Board's overall assurance arrangements.
Financial Assessment, including Value for Money	There may be financial consequences of individual WHCs however there is no direct financial impact associated with this report at this stage.
Quality, Safety and Patient Experience Assessment	Impact on quality, safety and patient experience are highlighted within the individual actions and assurance requirements contained within this report.
Equality and Diversity Impact Assessment (including child impact assessment)	There are no equality issues associated with this report at this stage, but equality impact assessment may be a feature of the work being undertaken as part of the actions.
Health and Care Standards	This report would contribute to the good governance elements of the Health and Care Standards.

Link to Integrated Medium Term Plan/Corporate Objectives	The actions will be aspects of the delivery of key priorities in the IMTP.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	WBFGA considerations are included within the consideration of individual actions.
Glossary of New Terms	None
Public Interest	Report to be published in public domain

WHC No	Date Issued	Review Date	Name of WHC	Summary	Status	Lead Executive (issued to)	Progress	Rating	Link
WHC/2022/007	15/02/2022	31/03/2023	**Recording of Dementia Read Codes**	Sets out the Read codes which should be captured by memory assessment and GP/ primary care services and recorded on all information shared between services, to the person living with dementia and their carer (if they wish to receive this information), and within the Memory Assessment Service, Learning Disability Memory Assessment Service and primary care data bases. It also sets out guidance for Welsh Health Boards to assist with the recoding of a diagnosis of dementia using the	Action	Director Primary Care, Community and Mental Health Services	Issued and Implemented	**complete**	recording-of-dementia-read-codes-whc-2022-007.pdf (gov.wales)
WHC/2022/014	01/03/2022	31/03/2023	**Healthcare associated infections and antimicrobial resistance improvement goals**	Extension of WHC to 31 March 2023	Action / Information	Director of Nursing	The HCAI Welsh Government expectations against the nationally reportable infections are reported at every PQSO Committee, with performance oversight via RNTG.	**complete**	amr-hcai-improvement-goals-for-2021-2023.pdf (gov.wales)
WHC/2022/011	24/03/2022	01/06/2022.. Update issued September 2022	**COVID-19 patient testing framework**	Updated guidance based on the need to introduce proportionate and effective changes which balance the risks from SARS-CoV-2 against the need to deliver routine and emergency healthcare safely, and the impact that testing regimes have on patients.	Action	Director of Therapies and Health Science	Issued and Implemented	**complete**	https://gov.wales/sites/default/files/publications/2022-05/patient-testing-framework-updated-guidance%20%282%29.pdf
WHC/2022/010	29/03/2022	N/A	**Reimbursable vaccines and eligible cohorts for the 2022 to 2023 NHS seasonal influenza (flu) vaccination programme**	General practices, community pharmacies and health boards/trusts should plan to order their influenza vaccine to match the high levels of uptake achieved in 2021-22	Action	Director of Public Health	Issued and Implemented	**complete**	https://gov.wales/sites/default/files/publications/2022-03/reimbursable-vaccines-and-eligible-cohorts-for-the-202223-nhs-seasonal-influenza-flu-vaccination-programme.pdf
WHC/2022/005	24/03/2022	31/03/2025	**Welsh Value in Health Centre: data requirements**	Health Boards and Trusts are required to supply the clinical audit/registry data to DHCW to support the work of the Welsh Value in Health Centre and in particular to: Continue to submit data to UK-wide clinical audit and outcome reviews and national PROMs platforms; Provide audit and PROMs data to DHCW for the purposes of creating visualisations and dashboards for Value Based Health Care approaches.	Action	Director of Digital	Issued and Implemented	**complete**	welsh-value-in-health-centre-data-requirements.pdf (gov.wales)
WHC/2022/09	04/04/2022	28/02/2023	**Prioritisation of COVID-19 patient episodes by NHS Wales clinical coding departments**	Due to the need for COVID-19 information to be as real-time as possible all NHS Wales Clinical Coding departments are asked to ensure that processes are put in place as soon as possible to ensure the following: All FCEs for patients with COVID-19 are identified upon discharge and prioritised by the Local Health Board/NHS Trust for the assignment of codes Such episodes of care are coded within the first week following discharge to allow for an accurate view of COVID-19 inpatient data on a weekly basis Each Local Health Board and NHS Trust to report their current numbers and percentages of uncoded COVID-19 and non COVID-19 episodes to Welsh Government (HSS.Performance@gov.wales) on	Compliance/ Action	Director of Planning and Performance	continue to prioritise the coding of COVID-19 patients as per the WG directive.	**complete**	https://gov.wales/sites/default/files/publications/2022-04/prioritisation-of-covid-19-patient-episodes-by-nhs-wales-clinical-coding-departments_0.pdf
WHC/2022/006	21/04/2022	30/04/2026	**Direct paramedic referral to same day emergency care: All Wales policy**	Publication of an all-Wales policy to support the Welsh Ambulance Services NHS Trust (WAST) and health boards in implementing direct paramedic referrals into Same Day Emergency Care (SDEC).	Action	Director of Operations	phased approach being implemented by the division	**In progress**	https://gov.wales/sites/default/files/publications/2022-04/direct-paramedic-referral-to-same-day-emergency-care-all-wales-policy.pdf
WHC/2022/13	27/04/2022	01/04/2023	**Health boards, special health authorities and trusts financial monitoring guidance 2022 to 2023**	2022/23 LHB, SHA and Trust monthly financial monitoring return guidance and associated submission templates.	Compliance	Director of Finance	Issued and Implemented	**complete**	202223-lhb-sha--trust-monthly-financial-monitoring-return-guidance.pdf (gov.wales)

WHC/2022/015	01/06/2022	N/A	**Changes to the vaccine for the HPV immunisation programme**	Information on the forthcoming changes to the human papillomavirus (HPV) immunisation programme. Aimed at health professionals who are responsible for delivering the programme. Share guidance with all those who are involved in delivering the national HPV vaccination programme in your area.	Action	Director of Public Health	Information on changes to schedules is cascaded centrally from PHW and WG	**complete**	changes-to-the-vaccine-for-the-hpv-immunisation-programme_0.pdf (gov.wales)
WHC/2022/16	01/06/2022	N/A	**The national influenza immunisation programme 2022 to 2023**	Increase in influenza vaccination coverage in all groups that are eligible for the vaccine, to best protect the Welsh public.	Action	Director of Public Health	Dual offer made alongisde covid in mass vaccination centres.	**complete**	https://gov.wales/sites/default/files/publications/2022-06/the-national-influenza-immunisation-programme-2022-23_1.pdf
WHC/2022/002	14/06/2022	01/04/2023	**NHS Wales national clinical audit and outcome review plan annual rolling programme for 2022 to 2023**	Full participation in all national clinical audits and outcome reviews listed in the annual National Clinical Audit & Outcome Review Annual Plan.	Information/ Action	Medical Director	As each National Clinical Audit (NCA) is published it will be added to the web based audit tracking system AMaT and assigned to a Clinical Lead. Full participation is expected in ALL NCAs. The NCA programme for 2022/23 will be shared with Clinical audit leads to allow planning for attendance at CSEG. AMaT is seen as the solution to effectively recording audit results, tracking progress and challenges and developing an action plan within a specific timeframe. AMaT training is being carried out throughout ABUHB. We are reviewing our ABUHB clinical audit strategy and will liaise with comms to raise awareness.	**In progress**	https://gov.wales/sites/default/files/publications/2022-06/nhs-wales-national-clinical-audit-and-outcome-review-plan-annual-rolling-programme-for-202223.pdf
WHC/2022/12	16/06/2022	31/12/2026	**Donation and transplantation plan 2022 to 2026**	Health boards and NHS trusts, where appropriate, are expected to work with the Welsh Health Specialised Services Committee (WHSSC), Welsh Renal Clinical Network (WRCN), NHS Blood and Transplant (NHSBT), Welsh Transplantation Advisory Group (WTAG), third sector and other relevant organisations towards implementing the priorities and actions in the Donation and Transplantation Plan for Wales. Health boards should take account of the priorities for donation and transplantation when planning their services and developing their	Action	Director of Planning and Performance	Plan is accounted for as part of IMTP planning processes.	**complete**	https://gov.wales/sites/default/files/publications/2022-06/donation-and-transplantation-plan-for-wales-2022-2026.pdf
WHC/2022/17	16/06/2022	31/12/2026	**Wales rare diseases action plan 2022 to 2026**	Highlight the publication of the Wales Rare Disease Action Plan (2022-2026).	Action / Information	Medical Director	The publication of the RDAP has been shared with clinical leads across several specialities. ABUHB are seeking to re-establish a local Rare Diseases Group and develop a local action plan to ensure adherence to the four key priorities outlined.	**in progress**	https://gov.wales/sites/default/files/publications/2022-06/wales-rare-diseases-action-plan-2022%E2%80%932026-whc-2022-017_3.pdf
WHC/2022/019	21/06/2022	01/04/2025	**NHS Wales non specialised paediatric orthopaedic services**	To ensure that this service specification is used to inform the delivery and commissioning of Non Specialised Paediatric Orthopaedic Services for children (aged up to 16 years) resident in Wales	Action	Director of Operations	Stakeholder response Proforma submitted in March 2022 outlining service provision of level 1 and level 2 services. Both services are able to be maintained in ABUHB with the current level of paediatric anaesthetic, radiology and general medical cover. Inter-organisational discussions between Consultants ongoing to agree on levels of transfer according to available capacity.	**In progress**	https://gov.wales/sites/default/files/publications/2022-07/non-specialised-paediatric-orthopaedic-services.pdf

WHC/2022/18	30/06/2022	N/A	**Suspected cancer pathway: guidelines**	Guidelines for Managing Patients on the Suspected Cancer Pathway	Compliance	Director of Operations	Fully compliant	**complete**	https://gov.wales/sites/default/files/publications/2022-07/guidelines-for-managing-patients-on-the-suspected-cancer-pathway_2.pdf
WHC/2022/20	22/07/2022	Continuous review	**Never events: policy and incident list July 2022**	Updated list of Never Events (remove wrong tooth extraction)	Compliance / Action / Information	Director of Nursing	SI team shared the WHC with the divisions and also published on the intranet	**complete**	https://gov.wales/sites/default/files/publications/2022-07/whc-2022-020-never-events-policy-july-2022.pdf
WHC/2022/21	28/07/2022	30/09/2022	**National optimal pathways for cancer**	The Quality Statement for Cancer requires that the nationally optimised pathways are fully embedded in local service delivery.	Action	Medical Director	Issued and Implemented	**complete**	https://gov.wales/sites/default/files/publications/2022-08/national-optimal-pathways-for-cancer-2022-update.pdf
WHC/2022/008	29/07/2022	01/05/2023	**New records management code of practice for health and care 2022**	Notification of the publication of the new Records Management Code of Practice for Health and Care 2022 and to advise Chief Executives, Directors of Social Care, Health and Care Records Managers and all line managers and supervisors within the relevant organisations that they should use it from May 2022.	Compliance / Action	Director of Digital	Issued and Implemented	**complete**	https://gov.wales/sites/default/files/publications/2022-07/new-records-management-code-of-practice-for-health-and-care-2022.pdf
WHC/2022/022	22/08/2022	01/08/2024	**The role of the Community Dental Service**	Updated guidance on the role of the community dental service, including the expansion of salaried dental officer posts, to support local communities who have limited or no access to general dental services normally provided by the independent contractor model. Ensure that arrangements are in place to implement this guidance	Action	Director of Primary, Community and Mental Health Services	Discussed at Primary Care Senior Leadership Team and satisfied that progress is being made in line with the WHC	**In progress**	https://gov.wales/sites/default/files/publications/2022-08/the-role-of-the-community-dental-service.pdf
WHC/2022/023	09/09/2022	N/A	**Changes to the vaccine for the HPV immunisation programme**	Information on the recently announced changes to the human papillomavirus (HPV) immunisation programme. Aimed at health professionals who are responsible for delivering the programme. Share the information with all those who are involved in delivering the national HPV vaccination programme in your area.	Information		Information on changes to schedules is cascaded centrally from PHW and WG	**complete**	changes-to-the-vaccine-for-the-hpv-immunisation-programme-whc2022023.pdf (gov.wales)
WHC/2022/026	11/10/2022	01/10/2023	**Approach for Respiratory Viruses – Technical Guidance for Healthcare Planning**	Letter to health professionals about the approach for responding to respiratory viruses over autumn and winter.	Action	Director of Public Health	Forwarded to relevant parts of the organisation.	**complete**	approach-for-respiratory-viruses-technical-guidance-for-healthcare-planning.pdf (gov.wales)
WHC/2022/027	24/10/2022	N/A	**Urgent polio catch-up programme for children under 5 years old**	Health Board's to carry out a 'targeted' immunisation catch-up programme across Wales. Targeting children under 5 with partial or no vaccination against Polio without delay. This is a priority project which will need to commence as soon as possible and be completed by 31 January 2023 at the latest, after which time the NES will no longer apply…."	Action	Director of Public Health / Interim Director Primary, Community and MH Services	Working group convened to delivery the catch up campaign by 31st Jan 2023	**In progress**	urgent-polio-catch-up-programme-for-children-under-5-years-old.pdf (gov.wales)

Aneurin Bevan University Health Board

Health Board Committee Assurance Note

Deferred Item	Consultant Job Planning Internal Audit Recommendations
Executive Lead	Dr James Calvert, Medical Director
Supported by	Sarah Simmonds, Director of Workforce and Organisational Development (WOD)
Reporting to:	Audit, Risk & Assurance Committee

Supporting Documents:
Appendix 1 - Recommendations of the Internal audit report - Pre-Pandemic

Summary

The Covid-19 Pandemic and early opening of the Grange University Hospital (GUH) had a direct impact on reducing our compliance with job planning. Health Board compliance for review of consultant job plans within 12 months was 27% as of 31 October 2022. The highest record pre-pandemic was 74% compliant (12 months).

Much of the work undertaken in response to previous audit reports and to support the opening of the GUH was appropriately halted to allow the challenges set by the pandemic to be met. However, this was re-energised following the second wave of the pandemic only to halt again as the Health Board responded to the impact of the Omicron variant at the end of 2021 and early part of 2022.

As previously reported to the Executive Committee, the coming together of clinical teams as part of the Health Board's new model of delivery of care has highlighted inconsistency in application of the Amendment to the Consultant Contract – Wales (2003) (consultant contract) through job planning, even within specialities.

A revised approach to job planning, including the proposed development of a detailed job planning procedure, considering lessons learned and good practice both internally and externally to the Health Board, was the subject of a previous paper to the Executive Committee.

This note, along with Appendix 1, seeks to reassure Committee members about the current status of Consultant Job Planning and provides an update on the specific actions taken prior to the COVID-19 pandemic. Following a detailed update to the People and Culture Committee in January, this Committee will receive a further assurance note.

The Audit, Risk & Assurance Committee is asked to note the current position against the Internal Audit Recommendations in respect of Consultant Job Planning.

APPENDIX 1 - Specific actions undertaken prior to the pandemic

Recommendation 1 – The Health Board should: • review the escalation process to ensure that it includes appropriate action following escalation to the Medical Director and holds medical staff to account for failure to have an in-date job plan; • produce action plans to address poor compliance and review these as part of the monthly divisional meetings with the COO. • complete job plans on an annual basis, as opposed to a 15-month cycle. • consider the process for reviewing job plans and look at ways of increasing compliance, such as aligning job planning dates with other activities (i.e., IMTP / Corporate Planning cycle); and • ensure that divisions and directorates have a process in place for a formal meeting with the consultant / SAS doctor in order to agree the job plan and implement an escalation / disciplinary process if there is not a legitimate reason for failure to agree a job plan.	
Actions previously undertaken	
1) A review of the escalation process was undertaken	3) Continued performance reporting and inclusion in workforce dashboard
2) Removal of the 15-month Health Board compliance time frame and adherence to the annual review	4) A review of the annual cycle- consideration was given to aligning to IMTP/planning cycle however this was discounted.

Recommendation 2 The Health Board should: • ensure that consultants and SAS doctors complete the correct pro-forma for job plan reviews; and • retain documentation as evidence that SPA activity has been discussed and reviewed at job plan reviews	
Actions previously undertaken	
1) The need to retain documentation from the job plan review, particularly in relation to discussion regarding SPA activity and the requirement to submit job plans on the approved proforma was communicated to all DDs and CDs.	2) The distance learning training pack includes the correct proforma as does all documentation on the medical and Dental Web page

Recommendation 3

The Health Board should ensure

- that objectives / outcomes within job plans in line with the British Medical Association Guidance Objective Setting – A Resource for Devising and Agreeing Objectives in the 2003 Consultant Contract' i.e., they should be SMART and include service objectives.

Actions previously undertaken

The requirement for SMART objectives for both SPA and DCC activity is included in the distance learning pack

Recommendation 4

The Health Board should ensure:

- that appropriate persons sign off job plans prior to submission; and
- job plans received by Medical and Dental Workforce that are not appropriately signed off, should be sent back to the respective division/directorate to ensure correct sign off.

Actions previously undertaken

The requirement for signed/agreed job plans is constantly reinforced. Job plans are not accepted for compliance recording unless there is evidence via e-mail trail that all parties agree.

Recommendation 5

The Health Board should ensure:

- divisions and directorates review all consultant and SAS doctors contracted hours to confirm they are scheduled for the correct number of sessions; and
- amendments following job plan reviews should be reflected in the job plan pro-forma and sent to Payroll once complete.

Actions previously undertaken

All local management teams reminded of the need to ensure that appropriate change forms are sent to Payroll for any changes in sessions or intensity supplements.

Aneurin Bevan University Health Board

AUDIT, RISK AND ASSURANCE COMMITTEE - STRATEGIC RISK REPORT

Executive Summary

This report provides an overview of all **33** strategic risks described on the Corporate Risk Register.

Response to the COVID-19 pandemic, through front line service delivery, restart and recovery plans, Primary and Secondary Care demand increase and associated risks continue to have the greatest impact on service delivery. This sustained response alongside increased demand for services continues to represent the most significant risks to the Health Board's delivery of its non-COVID-19 services and the achievement of the objectives outlined within the IMTP.

The Committee is requested to note the overview of the Corporate Risk Register at ***Appendix 1*** and the detailed risk assessments, for which the Committee is responsible at ***Appendix 2.***

The Board is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	X
Note the Report for Information Only	

Executive Sponsor:	**Rani Mallison, Director of Corporate Governance**		
Report Author:	**Danielle O'Leary, Head of Corporate Services, Risk and Assurance**		
Report Received consideration and supported by :			
Executive Team	**X**	**Committee of the Board**	**Audit, Risk and Assurance Committee**
Date of the Report: 22nd November 2022			
Supplementary Papers Attached: **Appendix 1 – Dashboard/Overview of Corporate Risk Register** **Appendix 2 – Committee Risk Assessments**			

Purpose of the Report

This report seeks to provide a summary of the current key risks which encompass the Corporate Risk Register and form the strategic risk profiles for the Health Board.

Background and Context

This report provides the Board with an opportunity to review the organisational strategic risks which receive oversight across all Committees and the Board.

The Health Board utilises the All-Wales Risk Matrix to assess the potential impact and likelihood of occurrence of all predicted risks to form an overall risk score. Risks may then be tolerated, treated, transferred or terminated in line with the Health Board Risk Management Strategy.

Internal controls and action plans are then developed to mitigate the risk and reduce either the likelihood, consequence, or both. Committees are then responsible for the active monitoring and review of all risks which receive oversight from each respective committee.

Risk Management ensures that the Health Board focuses on the risks and concerns that may impact on the organisations ability to deliver its objectives. Whilst active risk management is performed daily at an operational level, the Health Board's risk management strategy and process ensures that the Board is informed, engaged, and assured about the approach that Health Board uses to identify and respond to perceived risks.

The approach adopted by the Health Board to strengthen the alignment between Board and Committee business and the Board Assurance Framework continues to embed and provide a foundation for Board and Committee business to be risk based and focussed on assurance needs. This approach will also help to ensure the correct business is directed to the most appropriate committee.

Assessment and Conclusion

Committee Engagement, Wider Recommendations and Update on the Risk Management Strategy

The Risk Management Strategy and associated delivery approach was first endorsed by the Audit, Risk and Assurance Committee in August 2021, following which a benefits realisation plan was received and approved at the Committee in April 2022. An update on progress against the objectives within the strategy was presented to the last Committee meeting, a further update against objectives will be presented to the Committee in April 2023.

The Risk Management Strategy continues to embed across the organisation. Targeted work with Divisions and Directorates continues and further engagement and development of the Risk Management Community of Practice has been undertaken.

In addition to this, a review of the Health Board Risk Management Strategy has been undertaken and will be presented to the Committee as a draft version, as part of the wider organisational consultation process on the draft strategy.

Current Organisational Risk Profile:
At the November 2022 Board meeting, the Board approved the inclusion of an additional **7** risks to the Corporate Risk Register[1]. Therefore, there are now **33** Organisational Risk Profiles, of which **23** form Principal Risks due to the scoring being 15 or greater and are included within the Board Assurance Framework. The following table provides a breakdown of the risks and level of severity:

High	**23**
Moderate	**9**
Low	**1**

A high-level breakdown dashboard of all strategic risks including, current score, target score, risk appetite level, risk treatment and trend since last reporting period is included at ***Appendix 1***. The risks which comprise the corporate risk register continue to be reviewed and monitored via the Executive Team with complimentary Health Board escalation arrangements in place.

Changes in Risk Status Since Last Reporting Period

The Committee is requested to note that 4 risks on the Corporate Risk Register continue to be actively managed within an approved and agreed risks appetite/tolerance level, these are:
CRR023 – Avoidable harm to the population
CRR004 – WboFG Act and Socio-Economic Duty
CRR008 – Health Board estate being fit for purpose
CRR013 – Infection, prevention and control

A high-level breakdown dashboard of all strategic risks including, current score, target score, risk appetite level, risk treatment and trend since last reporting period is included at ***Appendix 1***.

Recommendation

The Committee is requested to:

- **RECEIVE** updates outlined within the risk profiles.
- **NOTE** the continued engagement and development with Divisions and local teams.
- **NOTE** the additional risks that have approved by the Board.

[1] At the time of writing, the Board has not met, this position will be clarified at the meeting.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The monitoring and reporting of organisational risks are a key element of the Health Boards assurance framework.
Financial Assessment, including Value for Money	This report has no financial consequence although the mitigation of risks or impact of realised risks may do so.
Quality, Safety and Patient Experience Assessment	This report has no QPS consequence although the mitigation of risks or impact of realised risks may do so.
Equality and Diversity Impact Assessment (including child impact assessment)	This report has no Equality and Diversity impact but the assessments will form part of the objective setting and mitigation processes.
Health and Care Standards	This report contributes to the good governance elements of the H & CS.
Link to Integrated Medium Term Plan/Corporate Objectives	The objectives will be referenced to the IMTP
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Not applicable to the report, however, considerations will be included in considering the objectives to which the risks are aligned.
Glossary of New Terms	Not required.
Public Interest	Report to be published.

Risk ref and Descriptor	Current Score	Target Score (informed by Appetite level)	Risk Appetite Level	Managed to Agreed Level Y/N?	Risk Treatment	Date and Trend Since Last Reporting Period	Assurance/ Oversight Committee	Risk Owner
CRR019 Failure to meet the needs of the population who require high levels of emergency supportive care and inability to release ambulances promptly to respond to unmanaged community demand. **(re-framed Dec 2021)**	20	15	**Low** level of risk appetite in relation to patient safety risks. **Moderate** levels of risk with regard to innovation around mitigations to prevent demand and better manage the demand.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(Oct 2022 ARAC)** 	**PQSO**	**Director of Operations**
CRR002 Failure to recruit and retain staff across all disciplines and specialities leading to adverse impacts on delivery of care to patients across acute and non-acute settings and non-compliance with safe staffing principles and standards. Nursing and	20	10	**Low** level of risk appetite in relation to potential patient safety risks. **Moderate** levels of risk with regard to innovation and changing roles to attract more staff and deliver services in different ways through new roles.	**No**	**Treat** the impact of the risk by using internal controls.	**(Oct 2022 ARAC)** 	**PCC**	**Director of Workforce and OD**

HCSW agencies refusing to contract with the Health Board. **[1](re-framed Nov 2022)**								
CRR013 Failure to prevent and control hospital and community acquired infections to include COVID-19	10	10	**Zero or low** due to patient safety and quality of service.	**Yes**	**Treat** the potential impacts of the risk by using internal controls.	**(Oct 2022 ARAC)** 	**PQSO**	**Director of Nursing**
CRR023 Potential risk to population health in relation to avoidable harm due to priority being given to management of the COVID pandemic.	20	20	**Zero or low** level of risk appetite in terms of protecting patient safety and the quality of services. **Moderate** level of risk appetite in relation to different ways of working to address backlog. This would include the use of technologies and innovations.	**Yes**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(Oct 2022 ARAC)** 	**PQSO**	**Director of Operations**
CRR007*re-framed July 2022* The Health Board model of care does not take into consideration the evolving needs of the population at this time	16	12	**Zero or low** level of risk appetite in terms of protecting patient safety and the quality of services. **Moderate** level of risk appetite in relation to some risk controls and mitigations is required due to interdependencies with partner organisations.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work and some are out of the Health Board's control.	**(Oct 2022 ARAC)** 	**PPHPC**	**Director of Primary, Community and Mental Health Services & Director of Public Health and Strategic Partnerships**
CRR010 Inpatients may fall and cause	15	10	**Zero or low** in the interests of patient safety.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Oct 2022 ARAC)** 	**PQSO**	**Director of Therapies and Health Science**

[1] Links to **CRR016** financial position due to impact of this part of the risk being realised.

injury to themselves.								
CRR027 Effectiveness of COVID vaccination and booster programme compromised leading to a Variant of Concern[2]	25	20	**Moderate** risk appetite level will need to be applied to this risk profile, given the unpredictability of the potential of variants of concern. The Health Board will ensure that it can behave appropriately to address the risk, should it materialise however, emergence of a variant of concern is beyond the Health Board's control.	**No**	**Treat** the potential impact of the risk with mitigations. **Tolerate** the unpredictable element of the VoC and other mutations.	**(Oct 2022 ARAC)** 	**PQSO**	**Director of Public Health and Strategic Partnerships**
CRR028 Continued inappropriate admissions of Children and Young People to adult mental health in-patient beds.	20	10	**Low** risk appetite level in relation to patient safety and experience. **Moderate** level risk appetite would be encouraged in order to explore more innovative ways of managing this risk alongside Health Board partners.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Oct 2022 ARAC)** 	**PQSO**	**Director of Primary, Community and Mental Health Services**
CRR003 Mental Health services will fail to meet the anticipated increased demand of the Health Board population, for Mental Health support, in light of the COVID 19 pandemic.	12	8	**Low** risk appetite level in the interests of patient safety. **Moderate** risk appetite levels will need to be taken to explore further innovations and appropriately reconfigure services and implement new arrangements.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(Oct 2022 ARAC)** 	**PQSO**	**Director of Primary, Community and Mental Health Services**

[2] This risk to incorporate CRR001 to describe an overarching population health vaccination risk for the next Board meeting.

CRR026 Risk to the general population and patients already within our services, due to less than adequate surge capacity to address any further exponential increase in pandemic response. ***links to Workforce risk – CRR002**	20	5	**Low** risk appetite level will be applied.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Oct 2022 ARAC)** 	**PQSO**	**Director of Operations**
CRR004 Failure to comply with WBoFG Act and Socio-Economic Duty	4	4	**Low to Moderate** - Risk appetite in this area is low in terms of compliance with the Legislation. However, further innovation is required to develop new approaches and ways of working therefore, risk appetite in this area is defined at a moderate level.	**Yes**	**Treat** the potential impacts of the risk by using internal controls. **Take Opportunities** and use positive risk management to realise efficiencies, better ways of working and realise our long-term strategic aims.	**(Oct 2022 ARAC)** 	**ARAC**	**Director of Public Health and Strategic Partnerships and Board Secretary**
CRR017 Partial or full failure of ICT infrastructure and cyber security	15	12	**Low** appetite in relation to adverse impact on Quality, Safety. **Moderate to High** level risk appetite for innovating to identify digital ICT system solutions.		**Treat** the potential impacts of the risk by using internal controls.	**(Oct 2022 ARAC)** 	**FPC**	**Director of Planning, Performance and ICT**
CRR016 Achievement of Financial Balance [3]	16	4	**Low** level of risk appetite in relation to the Health Board's financial statutory requirements. However, responding to COVID 19	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Oct 2022 ARAC)**	**FPC**	**Director of Finance and Procurement**

[3] Links to

			implications and maintaining safe services take precedence.					
CRR012 Inability to address health inequalities across the population leading to increased dependency on Health Board services in the longer term and impacts ability of achievement of strategic aims/objectives. **(re-framed Dec 2021)**	12	4	**Low** risk appetite in terms of patient safety and services**.** **Moderate** risk appetite with regard to innovation and developments in primary care and public health initiatives.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Oct 2022 ARAC)** 	**PPHPC**	**Director of Public Health and Strategic Partnerships**
CRR008 Health Board Estate not fit for purpose (**Re-framed Dec 2021**)	15	15	**Low** risk appetite in relation to adverse staff and patient experience due to poor Health Board estate. **Moderate** risk appetite with regard to innovation and developments across the Health Board estate.	**Yes**	**Treat** the potential impacts of the risk by using internal controls and continue to maintain the current position with ongoing monitoring and review. ***Although this has reached its target score, it is recommended that this risk continues to be monitored strategically as the impact/consequence should the risk be realised, is significant.***	**(Oct 2022 ARAC)** 	**FPC**	**Director of Operations**
CRR032 Failure to achieve underlying	16	12	**Low** level of risk appetite in relation to the Health Board's financial statutory requirements.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Oct 2022 ARAC)**	**FPC**	**Director of Finance and Procurement**

recurrent financial balance								
CRR033 (Dec 2021) Civil Contingencies Act Compliance	20	9	**Low** risk appetite in this area is low in terms of compliance with the Legislation.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Oct 2022 ARAC)** 	**FPC**	**Director of Planning, Performance and ICT**
CRR021 Welsh Language Act Compliance	12	8	**Low** risk appetite in this area is low in terms of compliance with the Legislation.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Oct 2022 ARAC)** 	**P&C**	**Director of Workforce and OD**
CRR025 Well Being of Staff and normalisation of risk	12	8	**Low** risk appetite in relation to adverse staff experience due to current and ongoing significant operational pressures.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Oct 2022 ARAC)** 	**P&C**	**Director of Workforce and OD**
CRR034 (April 2022) Disruption to Health Board services due to the Ukraine crisis.	10	5	**Low** risk appetite in this area in respect of patient safety however, a **higher** risk appetite will need to be applied when reviewing regional responses to the crisis and how the Health Board and its Partners can work collectively to address and mitigate the risks.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Oct 2022 ARAC)** 	**ARAC**	**Director of Planning, Performance and ICT**
CRR035 Sustainability of Primary Care Services due to increased demand, revised working patterns and continued response to	12	8	**Low** risk appetite in this area in respect of patient safety however, a **higher** risk appetite will need to be applied when exploring new and innovative ways of providing Primary Care Services.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some contributing factors are outside of the Health Board's control.	**(Oct 2022 ARAC)** 	**PPHPC**	**Director of Primary, Community and Mental Health Services**

Ukrainian refugee crisis.								
CRR036 Inability to deliver components of the Health Board's strategy and key priorities where the involvement of key Partners is essential	12	8	**Low** risk appetite in this area in respect of patient safety however, a **higher** risk appetite will need to be applied when exploring new and innovative ways of working alongside key Partners and acknowledge that some controls and mitigations are outside of the Health Board control.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Oct 2022 ARAC)** 	**PPHPC**	**Director of Planning, Performance and ICT.**
CRR037 Clinically unsafe and inappropriate inter-site patient transfers and into communities	15	5	**Low** risk appetite in this area in respect of patient safety.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Oct 2022 ARAC)** 	**PQSO**	**Director of Operations**
CRR038 Increased levels of patient acuity presenting resulting in an inability to staff appropriately and provide acceptable levels of care in line with best practice and guidelines.	15	5	**Low** risk appetite in this area in respect of patient safety.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Oct 2022 ARAC)** 	**PQSO**	**Director of Nursing/Director of Operations**
CRR039 Delays in discharging medically fit patients partly	20	10	**Low** risk appetite in this area in respect of patient safety however, a **higher** risk appetite will need to be applied when exploring new and innovative ways of working alongside key Partners and	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge	**(Oct 2022 ARAC)** 	**PQSO**	**Director of Operations and Director of Primary, Community and**

due to delays in accessing packages of care from Partners - *__covered in part by CRR019 on CRR (unmet demand and ambulance delays)__*			acknowledge that some controls and mitigations are outside of the Health Board control.		that some contributing factors are outside of the Health Board's control.			**Mental Health Services.**
Safeguarding ***CRR030 – (New risk/re-framed Nov 2022) *this risk has interdependencies with CRR002 Workforce Risk**** **Risk of:** 'Hidden Safeguarding Harms' experienced by patients in their homes and communities due to the COVID-19 pandemic and significantly increased demand on Health Board services.	16	8	**Low (averse to risk) Risk Appetite Level 2**	**No**	**Treat** the potential impacts of the risk by using internal controls.	**NEW RISK**	**PQSO**	**Director of Nursing**
Putting Things Right (PTR) – New Risk – Continued and sustained non-compliance with	20	8	**Low (averse to risk) Risk Appetite Level 2**	**No**	**Treat** the potential impacts of the risk by using internal controls.	**NEW RISK**	**PQSO**	**Director of Nursing**

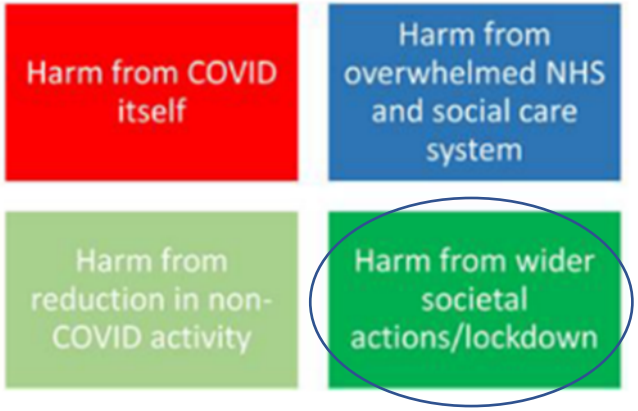
The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011								
Industrial Action – New Risk – Prospect of industrial action is growing as the RCN has already balloted its members. This presents an inability to deliver care to our patients should staff invoke their right to strike.	20	5	**Low (averse to risk) Risk Appetite Level 2**	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some contributing factors are outside of the Health Board's control.	**NEW RISK**	**PCC**	**Director of Workforce and OD**
External escalation of displaced people/migrants – Expected increase of displaced people into the Gwent area under the Home Office commissioned [section 98] accommodation. This presents a potential risk of further compounded demand for	16	10	**Low (averse to risk) Risk Appetite Level 2**	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some contributing factors are outside of the Health Board's control.	**NEW RISK**	**PPHPC**	**Director of Public Health/Director of Primary, Community and Mental Health Services**

services across areas of Gwent.								
Cost of living crisis – impact on population of Gwent and staff – New Risk – Levels of staff absence may increase due to the costs associated with travelling to and from work, increased demand for services as population unable to heat their homes adequately, especially impacting the elderly population of Gwent.	20	12	**Moderate (cautious risk taking) Risk Appetite Level 3**	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some contributing factors are outside of the Health Board's control.	**NEW RISK**	**PPHPC**	**Director of Public Health/Director of Workforce and OD**
Non-compliance with a key component of the new vision (2022-2027) for children's services is the Programme for Government commitment to remove private profit from the care of looked after children - Unregulated	20	10	**Low (averse to risk) Risk Appetite Level 2**	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some contributing factors are outside of the Health Board's control.	**NEW RISK**	**PQSO**	**Director of Operations**

placements are used for children and young people who present with significant risk and need bespoke care packages when spaces are not available in registered accommodations.								
LINC Programme – New Risk IF the new LIMS service is not fully deployed before the contract for the current LIMS expires in June 2025 THEN operational delivery of pathology services may be severely impacted RESULTING IN potential delays in treatments, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact.	25	5	**Low (averse to risk) Risk Appetite Level 2**	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some contributing factors are outside of the Health Board's control.	**NEW RISK**	**FPC**	**CEO**

<table>
<tr><td colspan="2">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</td><td colspan="3">Risk Description, Appetite and Decision</td></tr>
<tr><td colspan="2" rowspan="2">• This is an enabler risk and therefore impacts the Health Board's ability to achieve all objectives and strategic priorities</td><td colspan="3">CRR034 *this risk should be considered in conjunction with the new primary care sustainability risk*
Risk of: disruption of provision of Health Board services
Due to: External escalation of displaced people/migrants – Expected increase of displaced people into the Gwent area under the Home Office commissioned [section 98] accommodation. This presents a potential risk of further compounded demand for services across areas of Gwent.</td></tr>
<tr><td colspan="3">Impact
Potential workforce, resource and financial implications in responding to the crisis and requirement to provide healthcare and support to displaced people.</td></tr>
<tr><td>High Level Themes</td><td>• Partnership
• Quality and Patient Safety
• Patient Outcomes and Experience
• Finance
• Public Confidence
• Reputational</td><td>Risk Appetite</td><td colspan="2">Low (averse to risk)
Risk Appetite
Level 2</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="3">Risk Score</td></tr>
<tr><td>Audit, Risk and Assurance Committee</td><td>• Service Business Continuity Plans (BCPs)
• Service Contingency Plans
• Internal demand modelling data related to numbers of refugees incoming to the Health Board area.</td><td>Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td>Current Risk level after initial controls/mitigations have been implemented.</td><td>Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
</table>

	• Welsh Government guidance on healthcare provision for asylum seekers/refugees. • Internal bi-weekly meetings convened to report directly to Executive Team with escalations and by exception.						
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		3	5	2	5	1	5
Conduct analysis of Business Continuity Plans across sites and Divisions to ensure a state of readiness and ensure that this is communicated with key individuals across the organisation. Review and testing of Health Board Civil Contingencies Plans. Workforce colleagues identify and ensure support for staff who have family or friends in the Ukraine or Russia. Regular National engagement on the conflict and regular, collective impact assessments undertaken alongside Welsh Government.	Ongoing Ongoing Ongoing Ongoing	**15**		**10**		**5**	
Trend		**Executive Owner: Interim Director of Planning and Performance**					
Mapping Against 4 Harms of COVID		**Update**					



Nov 2022

A focus group has been established to meet monthly to discuss any potential risks as the crisis develops. This group will report to Executive Team by exception as and when required. The Community and Primary Care Division group meets weekly relating to the refugee workstream.

A clear governance structure from Welsh Government has not been agreed however, it is anticipated that it will likely report to the regional Public Service Board (PSB). Structures in place for different aspects of the resettlement sponsorship schemes. Each Local Authority managing the process in their Borough the Health Board work with and across the Local Authority areas. Governance routes already established consist of:

- Health Board Cyber security team liaise with the NCSC
- Business Continuity into the Tactical Business Continuity Group.

Health Board representatives from Emergency Planning Team and the Head of Risk and Assurance form part of the membership of the Gwent Tactical Local Resilience Forum where this specific risk is discussed with Partners. Opportunities for internal escalation are established with Head of Civil Contingencies reporting to Executive Team.

The sponsorship routes have supported increasing numbers of refugees, with visas issued to support relocation to Wales.

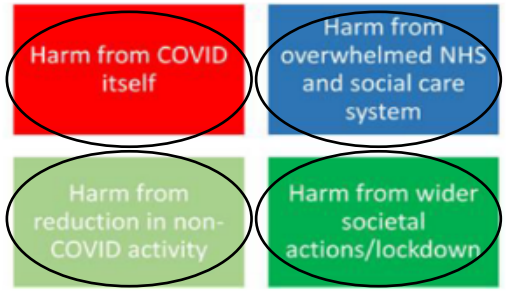
Each LA have been asked to identify suitable venues for refugee housing.
There are 2 Welcome centres in the Gwent area, the use of Hotels across Boroughs, and refugees housed with families.

The Health Board provides Health Assessment and screening for all refugees within agreed timeframes prior to individuals being registered with a General Practitioner in the local area.

<table>
<tr><th colspan="2">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</th><th colspan="2">Risk Description, Appetite and Decision</th></tr>
<tr><td colspan="2" rowspan="2">Getting it right for children and young adults
Supporting adults in Gwent to live healthy and age well
Provide high quality care and support for older adults
Staying healthy
Care closer to home
Less serious illness which require hospital care</td><td colspan="2">CRR004 (Nov 2021) – (Reframed)
Risk of Non-compliance with relevant Legislative requirements.
Due to The Health Board does not meet its statutory duty under the Well-Being of Future Generations (Wales) Act 2015 or the Socio-Economic Duty.

TAKE OPPORTUNITIES TREAT</td></tr>
<tr><td colspan="2">Impact
Negative impact on Health Board reputation and levels of public confidence would be low. If actions not taken to comply with the Acts, could potentially create sustained reliance on Health Care services in the future.</td></tr>
<tr><td>High Level Themes</td><td>Partnership
Research, Innovation Improvement Value
Quality and Patient Safety
Patient Outcomes and Experience
Health Inequalities
Financial
Public Confidence</td><td>Risk Appetite</td><td>Moderate (cautious risk taking)
Risk Appetite
Level 3</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="2">Risk Score</td></tr>
</table>

Audit, Risk and Assurance Committee	Programme Board in place to ensure the duties in the WBFA are applied across the organisation. Each Division has developed and agreed wellbeing objectives which have been signed off by Board and published. Organisational wellbeing objectives and PSB(s) wellbeing objectives reflected within the IMTP and Divisional Plans.		**Inherent** ***Risk level before any controls/mitigations implemented, in its initial state.***		**Current** ***Risk level after initial controls/mitigations have been implemented.***		**Target** ***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***	
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***		**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
			3	4	1	4	1	4
WBFA management arrangements to be reviewed post pandemic. Programme Board operations and wellbeing objectives to be re-set during 2022-23 to reflect maturity of WBFA arrangements. Development work is underway to incorporate the statutory obligations of the Socio-economic Duty to the corporate reporting templates of the Health Board to emphasise the importance of the Duty across the organisation.		Mar-23 Ongoing	**12**		**4**		**4**	
Trend			**Executive Owner: Director of Public Health and Partnerships and Board Secretary**					
Mapping Against 4 Harms of COVID			**Update**					

	Nov 2022: Pre-pandemic management arrangements to support adherence to WBFA requirements will be reviewed and re-set during 2022/23. This will reflect the post-pandemic position, as well as the ongoing prominence of the legislation in Wales. This will result in a re-statement of wellbeing objectives in the Health Board and a re-set of management arrangements. The Marmot Region programme of work through Gwent PSB is a significant demonstration of the Health Board's commitment to compliance with the Socio-Economic Duty. Inclusion of Gwent PSB's draft well-being objectives for the next five years to be taken forward as part of IMTP process.

Aneurin Bevan University Health Board

Update on Single Quotation and Tender Actions –
12th September 2022 to 10th November 2022

Executive Summary

This report highlights the number and value of Single Quotations / Tenders that have been submitted in the period 12th September 2022 to 10th November 2022

Appendix A refers in detail to the Single Quotations and Tenders.

The Board is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	✓
Note the Report for Information Only	

Executive Sponsor: Rob Holcombe – Interim Director of Finance, Procurement and Value Based Healthcare

Report Author: Rob Type – Assistant Head of Operational Procurement

Report Received consideration and supported by: NA

Executive Team		**Committee of the Board [Audit, Risk and Assurance Committee]**	

Date of the Report: 10th November 2022

Supplementary Papers Attached:

Appendix 1 – Summary of Single Quotation / Tender Actions

Purpose of the Report

This report provides Audit, Risk and Assurance Committee with an update in relation to the single tender / quotation action requests submitted to Procurement and is a standing report covering these key issues as part of the Committee's work plan for the year. The paper reports the outcome of these requests.

Appendix A provides specific detail regarding the Single Quotations / Actions that have been submitted and approved for the period 12th September 2022 to 10th November 2022.

Background and Context

It is a requirement of Aneurin Bevan Health Board Standing Orders and Standing Financial Instructions that all requests for a Single Tender action or a Single Quotation action are submitted to the Chief Executive for consideration. The Assistant Head of Operational Procurement will provide a summary for each Audit, Risk and Assurance Committee detailing all actions submitted for consideration.

Assessment and Conclusion

The Audit, Risk and Assurance Committee are asked to note the detail of the attached table (Appendix A) which details the number and value of items that are being submitted for a Single Tender or Single Quotation approval. The overarching guidelines on spending of public money are that it should be carried out in a fair, transparent, and open manner, ensuring that competition is sought wherever possible. Therefore, the number of single action requests should be kept to a minimum.

There have been 4 requests submitted which have been approved during the period with an annual value of £189,249.93.

Of these 4 approved requests, 4 were classified as service type arrangements.

None were within the scope covering on-going servicing / support of medical equipment, ICT Hardware/Software, or general licensing.

There were not any classified as goods purchased.

Recommendation

The Audit, Risk and Assurance Committee are asked to note the approved Single Tender and Single Quotation requests.

Appendix 1 - Summary of Single Tender/Quotation Actions

Date of Request	Type of Request	Reference No	Description	Anticipated Annual Value (ex VAT)	Supplier	Type	Reason for request	Advice from Procurement	Approved / Rejected	CEO Approval Date	Chairs Approval Date (If Applicable)
03/10/2022	Single Tender Action	ABU-STA-51235	Gritting Services - North Gwent	£40,064.00	MRI Whistance Ltd	Services	Continuity of gritting services across the North Gwent region for Winter 2022. Tendering is due to go live early 2023 to ensure a contract is in place in preparation for Winter 2023.	A Single Tender Action (STA) is appropriate for business continuity purposes and time sensitive commitments that need to made to the incumbent supplier	Approved - 05/10/2022	06/10/2022	Not Applicable
03/10/2022	Single Tender Action	ABU-STA-51237	Funeral Services	£42,000.00	Michael Ryan and Daughters Funeral Directors	Services	Continuity of funeral services across Aneurin Bevan Health Board. Tendering is due to go live early 2023 for a April 2023 start date	A Single Tender Action (STA) is appropriate for business continuity purposes with the incumbent provider - new contract will be in place from April 2023	Approved - 05/10/2022	06/10/2022	Not Applicable
27/09/2022	Single Tender Action	ABU-STA-51467	Water Sampling	£87,500.00	J&D Water Consultancy Limited	Services	Continuity of water sampling services across the health board which is required due to health and safety regulations/concerns. Currently working on going out to tender Q3 - 2022 for a new contract to be in place from April 2023	A Single Tender Action (STA) is appropriate for business continuity purposes with the incumbent provider - new contract will be in place from April 2023	Approved - 05/10/2022	06/10/2022	Not Applicable
07/07/2022	Single Quotation Action	ABU-SQA-51377	Qb ADHD Test Management System	£15,685.93	Qb Tech Limited	Services	Sole supplier providing an ADHD management system for children 6-18 years. Undertaking a one year trial of service to decide whether the Health Board want to enter into a longer term agreement, after reviewing business benefits	Unique product in the marketplace - from the market research undertaken - only one provider	Approved - 27/09/2022	03/10/2022	Not Applicable

Audit, Risk & Assurance Committee

Update on Governance, Financial Control Procedures and policies, Technical Accounting Issues, Public Sector Payment Policy Compliance and Payments in excess of £100K

Executive Summary

This report gives the Audit, Risk and Assurance Committee an update in relation to several standing items which are reviewed in line with the committee's terms of reference and work plan:

- Governance Issues including Financial Control Procedures and Policies.
- Technical accounting issues.
- Public Sector Payment Policy compliance.
- Payments Exceeding £100K.

The Audit, Risk and Assurance Committee is requested to:

- Note the contents of this report.

- Approve the amendments to the following financial control procedures (FCP):
  - Capital Assets and Charges

The Board is asked to: (please tick as appropriate)	
Approve the Report	✓ (FCP)
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	✓
Note the Report for Information Only	
Executive Sponsor: Robert Holcombe, Interim Director of Finance, Procurement and Value Based HealthCare	
Report Author: Estelle Evans, Head of Financial Services and Accounting	
Report Received consideration and supported by:	

Executive Team		**Committee of the Board [Audit, Risk and Assurance Committee]**	

Date of the Report: 03 November 2022
Supplementary Papers Attached: **Appendix 1 – Capital Assets & Charges Financial Control Procedure** **Appendix 2 – Financial Control Procedures Status**

Purpose of the Report
To provide the Audit, Risk and Assurance Committee with an update on the standing items listed in the Executive summary.
Background and Context
See Executive summary above.

Assessment and Conclusion

1. Financial Control Procedures (FCP)

The FCP to be reviewed at this Committee as part of the regular programme of updates is Capital Assets and Charges.

This has been presented and approved at the Executive Committee on 17 November.

A summary of the main changes to the Capital Assets and Charges Financial Control procedure is set out in section 1.1 below. The full revised FCP is included as Appendix 1.

1.1 **Capital Assets and Charges**

Owner: Director of Finance, Procurement and Value
Review Date: July 2022

The procedure sets out the requirements to ensure adequate controls over fixed assets.

Expenditure is capitalised if it meets the following criteria:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the UHB
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably; and
- the item has a cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward, or unit, irrespective of their individual or collective cost.

The purpose of the procedure is to set a control framework to ensure that fixed assets are properly used, secured, and accounted for correctly.

The document has been circulated for comment as follows:

- Interim Director of Finance, Procurement and Value

- Interim Assistant Finance Director – Financial Strategy and Planning
- Head of Capital Planning
- EBME Manager
- NWSSP-Audit and Assurance Services
- All Assistant Directors of Finance.

Main changes to the document

Paragraph	Summary of change
All	Organisational change - Director of Finance changed to Director of Finance, Procurement and Value
All	Intranet links added for internal documents
All	Name change – from District Valuer Services to Valuation Office Agency
7.1.2	Change in process - RFID Discovery System to track and verify assets introduced
7.2.4	Additional responsibility - the EBME Manager and Head of Capital Finance, 'to ensure that all capital equipment is assigned a unique RFID asset label where appropriate'
7.11	Change in process – Verification of assets process updated to include the use of RFID asset tagging in reference to annual audits
Appendix 1,2,3	Change in process – 'RFID Reference No.' added to the New Asset, Disposed/Obsolete/Condemned Assets and Transferred Asset forms

2. Technical Accounting Issues

Welsh Government have issued a technical update regarding an addendum to the Standing Financial Instructions on framework contracts. The details of the addendum are shown in section v) below. The revision introduced in point v) will be included formally in the next version of the Standing Financial Instructions.

"PROCEDURES FOR CONSENT FOR LOCAL HEALTH BOARDS TO ENTER INTO CONTRACTS EXCEEDING £1 MILLION

The latest version of the Standing Financial Instructions issued in April 2021 allows a number of exceptions where the requirement for consent by Welsh Government does not apply to:

i) Contracts of employment between LHBs and their staff.
ii) Transfers of land or contracts effected by Statutory Instrument Model Standing Orders, Reservation and Delegation of Powers for LHBs Schedule 2.1: Standing Financial Instructions Status: Update – March 2021.
iii) Out of Hours contracts.
iv) All NHS contracts, that is where one health service body contracts with another health service body.

Welsh Government believe that some confusion has arisen in relation to the procedures for the consent to enter contracts over £ 1 million when compared to guidance issued to NWSSP Procurement Services.

To ensure consistency between the SFIs and with guidance issued to NWSSP Procurement Services, further exceptions highlighted below should be applied to the SFIs.

v) **Contracts over £ 500k - £1 million (for noting) and £ 1 million + (for approval).**

i) Wales Public Sector Framework Agreements e.g., Frameworks established by National Procurement Services (NPS) or NWSSSP (not exhaustive) - <u>no further approval required to award contracts under these Frameworks through a direct award or mini competition.</u>

ii) Third Party Public Sector Framework Agreements e.g., Frameworks established by Crown Commercial Services, NHS Supply Chain (not exhaustive) – <u>no further approval required to award contracts under these Frameworks through a direct award.</u> Approval will however be required for award of contracts under these Framework Agreements through mini-competition or where the specification of the product/service required is modified from that stated within the Framework Agreement.

All Health Boards in Wales and Special Health Authorities bodies have been notified that these additional exceptions to the SFIs came into effect from 7th November 2000."

3. Public Sector Payment Policy (PSPP)

The following table shows the Public Sector Payment Policy performance for the month of October.

The Health Board has achieved 96.4% compliance of the number of Non-NHS creditors within 30 days of delivery of goods in October. The cumulative has further improved to 94.7%. In particular, there has been a significant improvement in the number of nurse agency invoices being processed in time following the formation of a multi disciplinary team, led by the Head of Management Accounts. Compliance in this area has risen from 84% at the beginning of the financial year to 96%. That group are now focussing on longer term improvements to the system and processes.

With regard to the NHS percentage the in-month and cumulative performance remains below the 95% target but has improved in recent months with ongoing action.

We are reminding all other Health Bodies that we are a "No Purchase Order No Pay" organisation for NHS invoices as well as Non-NHS which should help to further improve the percentage achieved in line with the target going forward.

Category	Invoices	In Mth %	YTD %
NHS	Value Number	86.5 89.5	92.3 87.3
Non NHS	Value Number	96.6 96.4	95.1 94.7

5. Payments in Excess of £100K

There were no exceptional issues to report.

Recommendation
The Audit, Risk and Assurance Committee is requested to approve the amendments to the Capital Assets and Charges Financial Control Procedure. The Audit, Risk and Assurance Committee are asked to note the other areas included within this report.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	*SFI's. SO's, Financial controls and accounting systems and processes form the basis of many organisational controls without which the organisation would be exposed to significant financial and reputational risk.*
Financial Assessment	*No direct financial implications but the financial governance issues covered in this standard Audit Committee paper set a framework of key financial controls for the organisation.*
Quality, Safety and Patient Experience Assessment	*Not applicable*
Equality and Diversity Impact Assessment (including child impact assessment)	*No adverse impact*
Health and Care Standards	*No applicable*
Link to Integrated Medium Term Plan/Corporate Objectives	*SFIs, SOs, Financial controls and accounting systems and processes form the basis of many organisational controls which form part of the delivery of financial targets and good governance.*
The Well-being of	*Not relevant*

Future Generations (Wales) Act 2015 – 5 ways of working	
Glossary of New Terms	*FCP – Financial Control Procedure* *SFIs - Standing Financial Instructions* *NWSSP - NHS Wales Shared Services Partnership* *RFID – Radio-Frequency Identification* *EBME – Electro Biomedical Engineering* *NPS – National procurement Services*

Aneurin Bevan University Health Board

Financial Control Procedure

Capital Assets and Charges

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

Status: DRAFT
Approved by: Audit Committee
Owner: Director of Finance
Issue date: DRAFT
Review by date: DRAFT
Policy No: ABUHB/Finance/0242

Contents:

1 Introduction

This procedure is to ensure that there are robust controls in place to set out the responsibilities of officers in relationship to the identification, accounting and security of capital assets.

2 Policy Statement

The procedure sets out the requirements to ensure adequate controls over fixed assets. The procedure is compliant with the Aneurin Bevan University Health Board (ABUHB) Standing Financial Instructions and should be read in conjunction with the Welsh Government IFRS NHS Wales Manual for Accounts and the Capital Procedures and Guidance notes Financial Control Procedure.

3 Aims

The purpose of this document is to set out clearly the responsibilities of staff within ABUHB with regard to fixed assets.

4 Objectives

The objective of this procedure is to set out a control framework to ensure that fixed assets are properly used, secured and accounted for correctly.

5 Scope

5.1 This procedure details the principle for purchasing, recording, transferring, disposing and general financial management of capital assets for ABUHB.

5.2 This procedure should be read in conjunction with the ABUHB Standing Financial Instructions, Capital Procedure and Guidance Notes and other financial procedures, for example,. Procurement, Accounts Payable etc. and the guidance in the capital chapter of the Welsh Government IFRS NHS Wales Manual for Accounts.

6 Roles and Responsibilities

6.1 The Director of Finance, Procurement and Value

Is responsible for:

- Maintaining an Asset Register to record the value of both purchased and donated assets.
- Calculating depreciation charges for each asset in use.

6.2 The Divisional Director of Facilities

Is responsible for:

- Managing ABUHB Land, Buildings and Engineering services including fittings.

6.3 Asset Owners

Asset Owners are managers who have responsibility for managing assets and are responsible for:

- Managing Capital Equipment used in their departments.
- The security of their assets and notifying the Head of Capital Finance of any changes to assets.

The Asset Owner is generally the Lead Manager who has submitted and signed the capital bid request. For new purchases, Asset Owners will need to be identified on the New Asset form (Appendix 1).

7 Main Body (General)

7.1 General

7.1.1 ABUHB operates the REAL Asset Management system (RAM) to record details of its Capital expenditure on fixed assets in the asset register.

7.1.2 ABUHB operates the Radio-Frequency Identification Discovery system (RFID) to track and verify assets that are able to be tagged with an RFID label.

7.1.3 Property, Plant and Equipment expenditure is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the UHB;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has a cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

7.1.4 Expenditure that does not meet this definition is known as revenue expenditure and is charged to budget holder's annual revenue budgets.

7.1.5 A full audit trail must be available to trace all Capital Expenditure incurred.

7.2 Purchase of Capital assets

7.2.1 Capital expenditure can be funded as follows:

- Discretionary Capital
- All Wales Capital Programme
- Internally generated funds e.g. disposal of existing assets
- Charitable donations
- Other /Welsh Government grants

The Capital Procedures and Guidance Notes Procedure deals specifically with the approval processes for Capital Expenditure with the Scheme of Delegation setting out the delegation of Capital Expenditure approval.

7.2.2 Following approval of a capital bid, Asset Owners will be required to complete a New Asset form (Appendix 1) for all new equipment and return to the Head of Capital Finance.

7.2.3 Upon receipt of the New Asset form from the relevant Asset Owner, the Head of Capital Finance will:

- Validate the asset.
- Assign a unique asset register number
- Update the asset record on the asset register with the equipment details provided.

7.2.4 The Electro Biomedical Engineering Manager (EBME) and Head of Capital Finance will ensure that all capital equipment is assigned a unique RFID asset label where appropriate.

7.3 Capitalisation of Assets held off site

7.3.1 Timing issues can arise regarding the capitalisation of assets at financial year end for which delivery has not yet been made. The Welsh Government IFRS NHS Wales Manual for Accounts sets out guidance to establish whether ownership, title and control are deemed to have passed to the Health Board to inform when expenditure can be capitalised.

7.3.2 In circumstances where assets are capitalised by the Health Board, but delivery of the asset has not taken place, budget holders in conjunction with procurement should ensure risks are assessed and managed regarding:

- Damage to assets whilst held by Supplier;
- Deterioration & obsolescence of assets whilst held by Supplier;
- Supplier insolvency.

7.3.3 If an asset is capitalised it should not be depreciated until brought into use, but it should be reviewed for impairment if held by the supplier for a significant amount of time.

7.4 Valuation of Assets

7.4.1 The following applies to the valuation of assets held by Aneurin Bevan University Health Board:

- All assets acquired will be added to the register at cost - cost includes all direct costs to bring the asset into operation.
- Land and Building assets will be subjected to a formal valuation exercise every five years (or as directed by Welsh Government) by the Valuation Office Agency or other body determined by the Welsh Government. This is also known as the quinquennial revaluation exercise.
- Land and Non-specialised in use properties will be held at market value for existing use.
- Specialised buildings will be held at depreciated replacement cost value as determined by the Valuation Office Agency.
- Assets under Construction will be held at cost and will be valued by the Valuation Office Agency on becoming operational.

7.4.2 Indexation will be applied to all assets as follows:

- Land and building assets in line with indices provided by the Valuation Office Agency.
- Indices for equipment will be provided from data compiled by NHS Wales Shared Services Partnership (formerly Welsh Health Estates).
- Indexation is applied from 1st April in each year.
- Assets under Construction, Assets Held for Sale and IT assets will not be subjected to indexation.

7.4.3 The Health Board through the Head of Capital Finance will annually consider whether all assets are still being held at their carrying amount or whether they have been subjected to an impairment. Impairment indicators can include:

Welsh Government Category –DEL. (Departmental Expenditure Limit)

- Loss or damage resulting from normal business operations.
- Abandonment of assets in the course of construction.
- The unnecessary over-specification of assets.

Welsh Government Category – AME. (Annually Managed Expenditure)

- Any loss as a result of a catastrophe.
- Unforeseen obsolescence.
- Change in use of an asset where specialised assets are no longer required for their original purpose.
- Revaluation on the movement of an asset from Asset under Construction into use following the first professional valuation.
- Revaluation in relation to an asset becoming surplus with plans to dispose.

On assessing whether an impairment has occurred the Head of Capital Finance will liaise with the relevant Asset Owner or Facilities department where land, buildings and dwellings are concerned.

7.5 Disposal of Assets

7.5.1 Items can be available for disposal because they are:

- Not capable of performing the required operational tasks or being upgraded to do so.
- No longer required, due to changed procedures, functions or usage patterns.
- No longer complying with occupational health and safety standards.
- Beyond repair but able to be sold for scrap.

7.5.2 The Asset Owner responsible for disposing of the equipment must be aware that:

- They are accountable for all decisions they take in the disposal process
- Proper accounting and audit procedures should be observed and all decisions documented.

7.5.3 Assets identified for disposal may be dispensed with using the procedures below. Acceptable methods of disposal are:

- Transfer of the asset to another part of ABUHB.
- Private Sale.
- Assets donated to a charitable organisation subject to the provisions set out below.
- Destroyed or recycled.

7.5.4 Choice of the most appropriate disposal option will normally be influenced by the age and functionality of the equipment for disposal and by market value.

7.5.5 In all cases assets disposed of must be reported on an 'Asset Disposal' form (Appendix 2) to ensure they are removed from the central Fixed Asset Register. A more detailed description of each disposal option is set out below.

7.5.6 Private Sale - for Property or Land Disposals the Divisional Director of Facilities must be notified of surplus assets that could be available for disposal. All Land and Property disposals of any limit must receive the written approval of Welsh Government to confirm consent to dispose.

For equipment disposals, managers should contact the local procurement department who can arrange for the surplus items to be sold at auction if appropriate.

7.5.7 Donations – ABUHB may authorise the donation of the equipment to another organisation. Such donations should be to organisations and not to individuals. The preferred recipient of such donations by the Health Board should be health or well-being related. All donations must be approved by the Manager.

7.5.8 Destroyed or Recycled Equipment - Items with no market value and no use to any other organisation or person may be destroyed in an appropriate and safe manner. An Asset Disposal form must be completed and authorised by the Asset Owner and forwarded to the Head of Capital Finance for removal from the Fixed Asset Register.

7.5.9 Donation or sale of active Equipment - Ensure the Client is aware that the recipient of the equipment should be advised in writing that ABUHB will not be liable for any Health and Safety issues surrounding the use of the equipment – sample wording is set out below:

"It is the recipient's responsibility to ensure that the equipment is suitable and safe for its intended use, installed correctly, and that it can be used without risk to health or safety. It is the recipient's responsibility to obtain any instructions for and advice on the installation and use of the equipment and to carry out or to have competent persons carry out all necessary checks appropriate to the equipment. Aneurin Bevan University Health Board will not be liable for any loss, damage, or injury arising out of the installation or use of the equipment, however caused".

Recipients should also be aware that maintenance is not included on the equipment.

7.5.10 All equipment recipients must be aware of the following: Aneurin Bevan University Health Board offers no warranty on the condition of the equipment it sells or donates. Sales or documentation should provide as full a description of the items as possible, specify that goods are sold 'ex works' or 'as is, where is', and invite prospective buyers/beneficiaries to inspect the goods before the sale/donation.

7.5.11 Summary of steps to be taken by Asset Owner on disposal:

- Identify assets for disposal.
- Validate serial numbers / identity of the asset with the Head of Capital Finance.
- Complete Asset Disposal sheet (Appendix 2) and forward to the Head of Capital Finance.
- Determine the market value of the asset.
- Select the best disposal option. If the item has a significant value then sale should be the preferred option.
- Remove items from maintenance arrangements.
- Obtain estimate of disposal costs (if required).

- Ensure clarity around no ongoing guarantee of quality is given where an asset is sold or donated.
- Ensure procedures are followed to remove any data from equipment prior to disposal.
- Oversee any sale including the collection of any income. Ensure that a receipt is given on sale / disposal / donation.

7.5.12 Upon receipt of the authorised Disposal Form from the relevant Asset Owner the Head of Capital Finance will:

- Validate the asset.
- Remove the item from the Asset Register and RFID Discovery asset tracking system.

7.5.13 Asset Owners must notify the Head of Capital Finance of any asset transfers by submitting a Transferred Assets form (see Appendix 3).

7.6 Donated Assets

7.6.1 Asset Owners must notify the Head of Capital Finance of all assets donated to the ABUHB that meet the capital definition in paragraph 7.1.3 of this procedure by submitting a New Asset form (Appendix 1).

7.6.2 Disposals and transfers of donated assets follow the same process as set out in 7.5 for owned assets.

7.7 Capital Expenditure Reporting

7.7.1 The Head of Capital Finance will be responsible for:

- Recording the capital expenditure incurred.
- Comparing actual capital expenditure against approved expenditure limits.
- Reporting the details to the Monthly Capital Group meeting.
- Submitting Capital Monitoring Returns and Project Progress Reports to Welsh Government as required.

7.8 Asset Register

7.8.1 The asset register must contain the minimum data set for all capital expenditure as defined in the capital chapter in the Welsh Government IFRS NHS Wales Manual for Accounts.

7.8.2 The asset register must be capable of calculating the annual depreciation for each asset. These charges must be calculated in accordance with the guidance in the capital chapter in the Welsh Government IFRS NHS Wales Manual for Accounts.

7.8.3 The Head of Capital Finance will be responsible for:

- Verifying expenditure deemed capital expenditure meets the capital definition.
- Entering the capital expenditure into the asset register.
- Reconciling capital expenditure entered in the asset register to that recorded in the ABUHB general ledger.
- Calculating, monthly, actual depreciation and posting the information into the general ledger.

7.8.4 The Head of Capital Finance will also be responsible for maintaining the asset register to record:

- Changes in valuation notified by the Valuation Office Agency.
- Changes in valuation arising from indexation.
- Details of assets transferred from one owner to another.
- Details of assets that are disposed/obsolete/condemned.
- Impairment of fixed assets.
- Accelerated depreciation.

The Head of Capital Finance must ensure that the relevant details are entered into the general ledger and ensure that such details reconcile to the asset register.

7.8.5 Asset lives used in calculating depreciation will be:

- Buildings – as notified by the Valuation Office Agency or other ABUHB nominated surveyor.
- Equipment – as per standard lives.

7.9 Owners Responsibilities

7.9.1 Owners are responsible for the security of their assets.

7.9.2 Owners must notify the Head of Capital Finance of any relevant asset information.

7.9.3 Owners must notify the Head of Capital Finance as soon as they are aware of the following:

- Details of new purchased or donated Assets following delivery to site (See Appendix 1).
- Details of assets that are disposed, obsolete or condemned (See Appendix 2).
- Details of transferred assets (See Appendix 3)
- Details of assets being replaced or planned to be replaced.
- Details of damage to assets.

- Details of any major parts of the asset that are replaced.

7.10 Divisional Director of Facilities Responsibilities

7.10.1 The Divisional Director of Facilities has additional responsibilities over and above owner's responsibilities.

7.10.2 The Divisional Director of Facilities is also responsible for:

- Liaison with the Valuation Office Agency when periodic revaluations are undertaken.
- Arranging for the Valuation Office Agency to revalue surplus buildings that are to be sold.
- Arranging for the Valuation Office Agency to revalue new buildings brought into use.
- Allocating building and engineering works capital expenditure to the appropriate asset block and asset category.
- Notifying the Head of Capital Finance of any changes affecting the revaluation of the estate.

7.11 Verification of Assets

7.11.1 The Head of Capital Finance will be responsible for undertaking RFID audits of equipment assets during each financial year to verify the existence of tagged assets. In some instances it may not be appropriate to tag an asset with an RFID label. For those assets not able to be verified via the RFID audits, the Head of Capital Finance will be responsible for writing to Asset Owners to request them to verify that their assets are still in their custody and being used.

7.11.2 The Head of Capital Finance will:

- Arrange RFID equipment audits to be undertaken at Health Board sites during the financial year.
- Following the audit, produce a list of each Owner's unverified assets as recorded in the asset register.
- Send the list to each Owner.
- Request the Owner to verify that the asset is still in use.
- Request Owners to return their asset verifications by the given date.

7.11.3 Asset Owners will:

- Assist with the RFID equipment audit process to locate tagged assets
- For assets unable to be verified during the RFID audit, respond to the written request to verify whether the asset is still in their custody and still in use.
- Notify the Head of Capital Finance, and provide a suitable explanation, of those assets that are no longer in use.

- Return the list to the Head of Capital Finance by the due date.

7.11.4 The Head of Capital Finance will:

- Ensure the RFID equipment audit data is reflected in the asset register
- Update the asset register to reflect the written verification of asset returns.
- Investigate any discrepancies between the asset register and the verification of asset returns.
- Calculate the impact on depreciation charges.
- Post the revised depreciation to the general ledger.
- Report Non Compliance with the annual verification process to Divisional Managers/ Executive Team.

7.12 Depreciation and Impairment Estimates

7.12.1 The Head of Capital Finance will be responsible for completing the Welsh Government's annual depreciation and impairment estimates in accordance with the guidelines provided.

7.12.2 The estimates will include the latest information on ABUHB's planned discretionary capital expenditure, expenditure on All Wales Capital Programme Schemes and planned disposals.

7.12.3 The Head of Capital Finance will be responsible for ensuring that the estimates are reviewed by the Assistant Finance Director – Financial Strategy and Planning and signed off by the Director of Finance, Procurement and Value.

8 Implementation

This document should be implemented with immediate effect.

9 Further Information

Enquiries regarding this policy should be directed to the Head of Capital Finance.

10 Audit

The Internal Audit programme shall, from time to time, review the compliance with this position. In addition External Audit may review compliance with this procedure as part of their financial accounts audit work.

11 Review

Every three years, unless there is a requirement to review it sooner.

Appendix 1

Aneurin Bevan University Health Board

NEW ASSET

1. Asset Details

Capital Asset No.	
Asset Description	
Model	
Serial No.	
EBME Reference No.	
RFID Reference No.	
Supplier Name	
Manufacturer	
Asset Value	
Date Received	

2. Site, Department & Owners Details

Site	
Ward/Room Location	
Department	
Owners Name	
Owners Designation	
Signed	
Contact Telephone No.	
Date	

3. Return to:

Head of Capital Finance, Finance Department, Ground Floor, Portacabins, Llanfrechfa Grange, Llanfrechfa, Cwmbran.

Appendix 2

Aneurin Bevan University Health Board

DISPOSED/OBSOLETE/CONDEMNED ASSETS

1. Asset Details

Asset No.	
Asset Description	
EBME Reference No.	
RFID Reference No.	
Model/Serial No.	
Reason For Disposal	
Method of Disposal	
Date Disposed	
Sale Proceeds	

2. Site, Department & Owners Details

Site	
Department	
Owners Name	
Owners Designation	
Contact Telephone No.	
Signed	
Date	

3. Return to:

Head of Capital Finance, Finance Department, Ground Floor, Portacabins, Llanfrechfa Grange, Llanfrechfa, Cwmbran.

Appendix 3

Aneurin Bevan University Health Board

TRANSFERRED ASSETS

2. Asset Details

Asset No.	
Asset Description	
EBME Reference No.	
RFID Reference No.	
Model/Serial No.	
Reasons For Transfer	
Date Transferred	

4. Site, Department & Owners Details

	Original	**New**
Site		
Department		
Owners Name		
Owners Designation		
Signed		
Date		

5. Return to:

Head of Capital Finance, Finance Department, Ground Floor, Portacabins, Llanfrechfa Grange, Llanfrechfa, Cwmbran.

Summary Position on Financial Control Procedures

FCP	Year Due	Approved	Committee Approved	Review Date	Notes
Capital Assets and Charges	22/23	Due for review		19-Jul-22	Dec 22 Audit Committee
Engaging Off Payroll Workers	22/23	Due for review		01-Dec-22	Scheduled for Feb 23
Counter Fraud Bribery and Corruption Policy	22/23	Not yet due		25-Feb-23	Scheduled for Feb 23
Accounts Payable	23/24	Not yet due		02-Apr-23	Scheduled for Feb 23
Patients' Property	23/24	Not yet due	Apr-20	02-Apr-23	Scheduled for Feb 23
Purchasing Cards	23/24	Not yet due	Apr-20	02-Apr-23	Scheduled for Feb 23
Capital Procedures and Guidance Notes	23/24	Y	Apr-20	02-Apr-23	
General Ledger	23/24	Y	Apr-20	02-Apr-23	
Policy and Governance approach for Commissioning Additional (External & Insourced) Non NHS Clinical Services	23/24	Y	Apr-20	02-Apr-23	
Prepayment of Goods and Services	23/24	Y	Jul-20	13-Jul-23	
Patients' Travel Costs Policy	23/24	Y	Oct-20	22-Oct-23	
Cash and Bank	23/24	Y	Oct-20	22-Oct-23	
Petty Cash	23/24	Y	Dec-20	03-Dec-23	
Petty Cash - Mental Health	23/24	Y	Dec-20	03-Dec-23	
Accounts Receivable	23/24	Y	Feb-21	04-Feb-24	
Approval of Orders over £100K	23/24	Y	Feb-21	04-Feb-24	
Salary Sacrifice	24/25	Y	Aug-21	12-Aug-24	
Policy for Out of Area Referrals to Secondary Care	24/25	Y	Aug-21	12-Aug-24	
Overseas Visitors	24/25	Y	Feb-22	03-Feb-25	
Charitable Funds	25/26	Y	Apr-22	19-Jul-25	
Recovery of Overpayments to Employees	25/26	Y	Aug-22	02-Aug-25	
Budgetary Control Policy & Procedure	25/26	Y	Aug-22	02-Aug-25	
Losses and Special Payments	25/26	Y	Oct-22	06-Oct-25	
Stores & Stocks	25/26	Y	Oct-22	06-Oct-25	

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board 1st December 2022 Agenda Item:3.3

Aneurin Bevan University Health Board

Audit, Risk & Assurance Committee

Capital Finance Update – Asset Tagging & Verification 2022/23

Executive Summary

This report sets out the progress and forward plan for asset verification and tagging within Aneurin Bevan University Health Board.

A new I.T system has been implemented and tagging is well underway for both capital assets and EBME assets. Nil book value assets verification was flagged as a risk in 21/22 audit and therefore there has been a focus in this area, along with high gross book value areas. This focus is intended to enable the Health Board to verify a material level of assets within 2022/23.

Where assets are not verified by tagging in the financial year a manual exercise will be completed but this will be materially reduced compared to previous annual verification exercises.

The Committee is asked to note the progress and the forward plan as assurance that the Health Board is working to reduce this audit risk.

The Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	√
Note the Report for Information Only	

Executive Sponsor: Rob Holcombe – Interim Director of Finance, Procurement & VBHC

Report Author: Suzanne Jones – Interim Assistant Director of Finance

Report Received consideration and supported by:

Executive Team		**Committee of the Board**	√

Date of the Report: 3rd November 2022

Supplementary Papers Attached:

1. Glossary

Purpose of the Report

The Committee is asked to note:

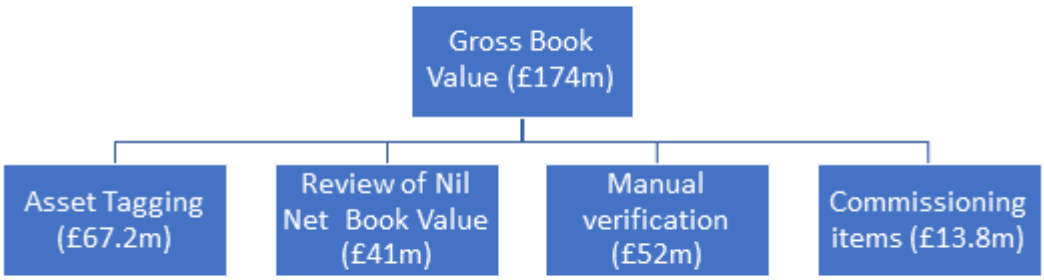
- The Asset tagging / verification progress in 2022/23, and
- The Asset tagging / verification plan for the remainder of 2022/23.

Assessment & Conclusion

Asset verification within the HB has historically been completed by a manual verification exercise by Divisions in quarter 4 of the financial year. This entails the Division confirming the asset exists by completing and returning a pre-populated excel spreadsheet from Capital Finance. During the 21/22 audit there was an issue raised regarding assurance over the existence of fully depreciated equipment assets. Additional verification of the gross book value of these assets was completed during the audit period and evidence provided to successfully provide assurance to the auditors to enable the accounts to be signed off.

The gross book value of ABUHB capital assets as at 30th September is £174m.

Capital finance have prepared a plan to increase the reliability of the verification of the assets. The approach is described below:



Asset Tagging

The HB had already purchased an RFID asset tagging system – RFID Discovery. Implementation of the system has taken longer than expected due to issues in configuring the interface between Health Board systems in capital (Fixed Asset Register) and EBME (electro biomedical engineering) with the provider company. It was agreed to include EBME revenue assets in the project at the same time to maximise the benefit of the system.

Tagging enables an RFID tag to be placed on the asset, which is then scanned into the system to confirm that the asset exists and records where the asset is located. New equipment assets are being tagged as they are commissioned, however, the tagging of all historically purchased equipment assets is a time-consuming process.

A plan has been produced to have tagged approx**. £67.2m GBV assets by year end, of which 52.4% have already been tagged**. This is an optimistic plan and carries risks.

Priority is being given to areas with the highest asset GBV's, and those in the same location on visits, however, this is also influenced by the Division's ability to prioritise this work.

Risks include:

- Staff time to complete the pre visit checks both in Capital and the Divisions

- Site visits, this is dependent on the Divisions hosting and providing a dedicated person who can assist in locating the assets
- Site time visits are limited due to services and patient confidentiality, so they need to be carefully arranged.
- Site visits can be impacted by Covid / Covid rules
- Successful of visits can be impacted by access to the correct I.T and disruptions to systems
- Assets being where they are supposed to be

The Capital finance team have one member of staff available to do this as part of a wider role. Additional help has been made available by the finance department in terms of trainees to complete some of the pre checks which require reconciliation between the Medusa system, Capital system and using Oracle for purchase order and serial numbers. The Capital finance team have advertised a band 4 post partially to assist in achieving this plan. If this post is not filled there is further risk to achieving the above tagging plan.

Nil Net Book Value

A large number of nil book value assets were verified in May 2022 in relation to the audit. For the remaining assets not verified during the audit period, the Capital finance team has circulated a verification return to Divisions asking them to confirm if the assets are still in use. The deadline for responses was the 16th of September but to date there has been few responses. Chasing emails have been sent with responses being collated, this will be escalated if further responses have not been received.

Nil book value assets will either be confirmed or written off, this will verify approximately **£41m of which 51.7% have already been verified.**

Manual Verification

Any assets that are not verified by tagging or the nil NBV verification exercise will need to be manually verified in line with the Health Boards FCP. This will require a list of assets to be sent to the Division to be verified, however, in some cases photographs to provide proof it exists may be required. Photographs were required by audit in lieu of their field visits.

The list of assets sent to divisions will to a degree be cleansed of nil net book value assets and tagged items making the exercise more straight forward for the Divisions.

The current plan is to send these lists for manual verification out late December for return January 2023 to allow for time for any accounting adjustments and updates to the system ready for the 2022/23 accounts.

Manual verification is likely to be required for approximately **£52m which will be verified in quarter 4.**

Commissioning Assets

These are items that are normally classed as revenue expenditure, as they are below the Health Board's capitalisation threshold (£5k) but are capitalised as part of commissioning a new building such as the GUH. Items include low value furniture and

equipment such as beds and bins. These items would not be appropriate for RFID tagging and are normally excluded from the manual verification because of the nature of the asset. Instead, the HB assigns these assets a standard useful life on capitalisation and then write off the assets when they are fully depreciated. It is not planned to move away from this for 22/23, however, the Capital Finance team will review the assets classed as commissioning during November with a view to reviewing their useful life.

This reduces the overall GBV to be verified by £13.8m (currently £9m of the commissioning asset value relates to items purchased for the opening of GUH).

Conclusion

The plan is for all assets to have some form of verification in this financial year, this may be achieved through tagging, the review of nil book value assets or via a manual verification exercise. There will undoubtedly be a percentage of assets that will remain outstanding for verification, due to the ability of the Divisions to undertake the exercise, but this is expected to be minimal and immaterial for the accounts.

The appendix demonstrates the planned approach in a table form for ease of reference.

Achievement against the plan will be measured following year end reporting, with a new plan to further progress asset tagging and verification for 2023/24.

Recommendation

The Committee is asked to note:

- The Asset tagging / verification progress in 2022/23, and
- The Asset tagging / verification plan for the remainder of 2022/23.

Appendix

Appendix 1 – Asset verification approach 2022/23

	Year End Plan £	Actions	When by:
Equipment Assets GBV as at 30.09.22	174,105,849		
Commissioning Assets	13,775,734	Review	15.11.22
Balance to be Verified	**160,330,115**		
RFID Tagging Exercise			
Tagged to September	35,224,695	Complete	Complete
Forecast Additional Tagging by 31.03.22	32,024,338	Site Visits Planned before end of year	31.03.22
Sub Total	**67,249,033**		
Nil NBV Assets Verification			
Verified by September	21,283,704	Complete	Complete
Awaiting Responses	19,883,502	Returns have been sent out and requested back by the 16.09.22 - non responses are being chased with Directorates	09.12.22
Sub Total	**41,167,206**		
Further Manual verification of Assets not yet tagged / Unable to be tagged	51,913,876	Manual verification returns to be set out to Directorates mid-December for return by End of January	31.01.22
Total	**160,330,115**		

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Risks of not reducing the audit risk identified in 2021/22.
Financial Assessment, including Value for Money	This paper provides details of the asset verification and tagging exercise for 2022/23.
Quality, Safety and Patient Experience Assessment	This paper links to AQF target 9 – to operate within available resources and maintain financial balance. This paper provides a financial assessment of the Health Board's delivery of its IMTP priorities and opportunities to improve efficiency and effectiveness.
Equality and Diversity Impact Assessment (including child impact assessment)	The Assessment forms part of the IMTP service plan.
Health and Care Standards	This paper links to Standard for Health services One – Governance and Assurance.
Link to Integrated Medium Term Plan/Corporate Objectives	This paper provides details of the financial position that supports the Health Board's 3 year plan. The Health Board has a statutory requirement to achieve financial balance over a rolling 3 year period.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** Long-term financial linked to IMTP completion **Integration –** Regional partnership and integration with other NHS Wales organisations **Involvement –** use of environmental fund and specific investment as well as on-going links with services for engagement **Collaboration** – collaboration with external partners **Prevention** – long-term strategy to provide investment and savings through preventative measures across the UHB.
Glossary of New Terms	See Below
Public Interest	Circulated to Audit, Risk & Assurance Committee members and available as a public document.

Glossary

NBV – Net Book Value	GBV – Gross Book Value	FCP – Financial Control Procedure
GUH – Grange University Hospital	RFID – Radio Frequency Identification	EBME – Electro Biomedical Engineering

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit, Risk & Assurance Committee Thursday 1st December 2022 Agenda Item:4.1

Aneurin Bevan University Health Board

Counter Fraud progress report to Audit Committee 1st December 2022

Executive Summary			
An executive overview has been prepared for the Aneurin Bevan University Health Board (ABUHB) Audit, Risk and Assurance Committee. It highlights the Counter Fraud work which has been undertaken by the Local Counter Fraud Specialist (LCFS) to date during financial year 2022/23.			
The Board is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views	√		
Receive the Report for Assurance/Compliance			
Note the Report for Information Only	√		
Executive Sponsor: Robert Holcombe – Director of Finance			
Report Author: Martyn Edwards – Head of Counter Fraud			
Report Received consideration and supported by: Director of Finance			
Executive Team		**Committee of the Board [Committee Name]**	**Audit, Risk and Assurance Committee**
Date of the Report: 18th November 2022			
Supplementary Papers Attached: No			

Purpose of the Report

To update the Committee of work progress of Counter Fraud Team

Background and Context

This document has been prepared by the Aneurin Bevan University Health Board Counter Fraud Team in order to comply with legal directions and the NHS requirements of Government Functional Standard 013: Counter Fraud.

Assessment and Conclusion

This report will contribute towards the annual Quality Assurance Self-Review as evidence that ABUHB has complied with the aforementioned Functional Standards.

Counter Fraud Staffing

Following the departure of two LCFS from the team, the Fraud Team has now returned to a full staffing compliment with the appointment of two replacement investigators. This compliment of new personnel has resulted in an increase to 3.0 wte staff in comparison to the 2.8 wte staff as previously stipulated on the corporate structure.

Furthermore, a recruitment drive has taken place as part of succession planning in relation to the post of Head of Counter Fraud and this has been advertised, from a recruitment perspective, for the second occasion. Interviews of suitable applicants are anticipated to take place in December 2022. If this process is successful, it will allow for a handover period for the said post.

Issues
One newly appointed LCFS was fully accredited and consequently had no immediate training and development requirements. The second LCFS; however, will be required to complete a national fraud foundation course which is accredited by the Professional Accreditation Board. Following this process (which will not be available until early 2023) nomination will then be necessary with the NHSCFA before the LCFS can by fully functional from an operational perspective.

Staff awareness
The fraud awareness programme undertaken by the LCFS is reaching its target audience and all mediums have been fully promoted and exploited with an aim of actively encouraging the reporting of fraud referrals. Sixteen (16) such referrals have been received this financial year to date.

In ABUHB, for PADR purposes, Counter Fraud awareness input at Corporate Induction and the fraud awareness e-learning programmes remain mandatory requirements. Financial year to date, 828 members of staff have received fraud awareness training, which consists of Corporate Induction and face-to-face presentations combined. This is currently the highest headcount figure of the 7 NHS Health Boards in Wales.

Furthermore, the total staff uptake figures for the All-Wales Counter Fraud e-learning module for ABUHB stands at 3,070 which is currently the third highest NHS Health Board figure in Wales.

During November 2022, the LCFS has been engaged in national fraud awareness week. This has resulted in LCFS roadshows at ABUHB hospital sites using displays and promotional goods such as pens, post-it pads, keyrings, coasters etc, all of which were provided by the NHSCFA. This awareness programme has also encompassed the dissemination of staff newsletters, fraud notices on both the ABUHB intranet and ESR system carousels together with the generation of staff payslip fraud messages.

National Fraud Initiative
The LCFS complied with all requirements for the mandated 2022-23 NFI data uplift. The resulting data matches for this exercise are anticipated in February 2023.

Strategic Governance
The LCFS has reviewed and significantly revamped the Counter Fraud Bribery & Corruption Policy to ensure the policy is aligned to the 12 components/requirements of mandatory Government Functional Standard 013: Counter Fraud. The policy is currently undergoing approval of Executive Committee. Additionally, the LCFS actively continues to review and fraud proof each and every Health Board Policy that requires the approval of the Workforce & OD Policy Group.

Reactive counter fraud activity
A list of current investigations is detailed in Appendix (1). This incorporates financial recoveries amounting to £84,763.06, which includes investigation costs awarded at court of £1,124.69.

Fraud prevention activity
The LCFS has actioned the following fraud prevention notice during Q.3.
FPN H-004-22 - CFO Cyber Enabled Mandate Fraud.

Recommendation
This report is intended for Audit Committee information and views.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	N/A
Financial Assessment, including Value for Money	N/A
Quality, Safety and Patient Experience Assessment	N/A
Equality and Diversity Impact Assessment (including child impact assessment)	N/A
Health and Care Standards	N/A
Link to Integrated Medium Term Plan/Corporate Objectives	N/A
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** N/A
	Integration – N/A
	Involvement – N/A
	Collaboration – N/A
	Prevention – N/A
Glossary of New Terms	N/A
Public Interest	N/A

Appendix 1

INDEX OF LCFS INVESTIGATIONS AS AT 18th November 2022					
Case	**FIRST Ref**	**Health Body**	**Area**	**Subject**	**Status**
1.	WARO/19/00145	ABUHB	NHS Staff	Falsify WLI claims.	CPS declined charging decision.
2.	WARO/19/00122	ABUHB	General Practitioner	Falsify information on application for Welsh G.P. performers list.	Subject has been interviewed under caution. CPS declined to charge. Subject has been suspended from practising by GMC pending fitness to practice hearing.
3.	WARO/20/00020	ABUHB	NHS Staff	Working elsewhere whilst on sick leave.	NFA on criminal aspect. Dismissed from employment on 21/10/2020 following disciplinary action. NMC sanction impending.
4.	WARO/21/00003	ABUHB	NHS Staff	Theft of medication.	Dismissed for gross misconduct on 10/08/2021 following disciplinary action. Police sanction Women's pathway. NMC sanction impending.
5.	INV/21/00267	ABUHB	NHS staff	Dishonest retention of salary overpayment.	NFA on criminal aspect. Subject no longer employed by ABUHB. Civil recovery of £28,328.68 implemented. Case closed 12/08/2022.
6.	INV/21/00276	ABUHB	NHS staff	Dishonest retention of salary overpayment.	At Merthyr Tydfil Crown Court on 6th September 2022, the defendant was sentenced to 8-months imprisonment, suspended for 12-months, was ordered to pay £1,124.69 investigation costs, pay £156.00 victim surcharge and perform 100 hours of unpaid work. (The defendant had already repaid ABUHB in advance of the court hearing on 25th August 2022, against a fraud loss value of £21,389.69.

INDEX OF LCFS INVESTIGATIONS AS AT 18th November 2022					
Case	**FIRST Ref**	**Health Body**	**Area**	**Subject**	**Status**
7.	INV/21/00294	ABUHB	NHS Staff	Falsification of hospital appointments.	Investigation ongoing.
8.	INV/22/00060	ABUHB	Member of public	NHS compensation claim.	Investigation ongoing.
9.	INV/22/00110	ABUHB	NHS staff	Timesheet fraud.	Investigation ongoing.
10.	INV/22/00123	ABUHB	NHS staff	False declaration on job application form.	Investigation ongoing in joint venture with Gwent Police.
11.	INV/22/00388	ABUHB	NHS staff	Dishonest retention of salary overpayment.	Disciplinary and civil action impending.
12.	INV/22/00529	ABUHB	Member of public	Illegal supply of prescription drugs.	Joint investigation with Police, criminal charges to be proffered.
13.	INV/22/00690	ABUHB	NHS staff	Working elsewhere whilst on sick leave.	Investigation ongoing.
14.	INV/22/00691	ABUHB	NHS staff	Working elsewhere whilst on sick leave.	Investigation ongoing.
15.	INV/22/00692	ABUHB	NHS staff	Working elsewhere whilst on sick leave.	Investigation ongoing.
16.	INV/22/00693	ABUHB	NHS staff	Dishonest retention of salary overpayment.	NFA on criminal aspect. No disciplinary issues identified. Financial recovery of £33,920.00 implemented. Case closed 01/08/2022.
17.	INV/22/00899	ABUHB	NHS staff	Working elsewhere whilst on sick leave.	Investigation ongoing.
18.	INV/22/00925	ABUHB	NHS staff	Overtime fraud.	Investigation ongoing.
19.	INV/22/00926	ABUHB	NHS staff	Overtime fraud.	Investigation ongoing.
20.	INV/22/01183	ABUHB	NHS staff	Timesheet fraud.	Investigation ongoing.

INDEX OF LCFS INVESTIGATIONS AS AT 18th November 2022					
Case	**FIRST Ref**	**Health Body**	**Area**	**Subject**	**Status**
21.	INV/22/01195	ABUHB	NHS staff	Drug fraud.	Investigation ongoing.
22.	INV/22/01184	ABUHB	NHS staff	Timesheet fraud.	Investigation ongoing.
23.	INV/22/01201	ABUHB	NHS staff	Timesheet fraud.	Investigation ongoing.
24.	INV/22/01391	ABUHB	NHS staff	Dishonest retention of salary overpayment.	Investigation ongoing.
25.	INV/22/01353	ABUHB	Member of public	Prescription fraud.	Investigation ongoing.
26.	INV/22/01702	ABUHB	NHS staff	Working elsewhere whilst on sick leave.	Investigation ongoing.

Internal Audit Progress Report

Audit, Risk and Assurance Committee

December 2022

Aneurin Bevan University Health Board

NWSSP Audit and Assurance Services

Contents

1. Introduction

The purpose of this report is to:

- highlight progress of the 2022/23 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board') to the December 2022 Audit, Risk and Assurance Committee;
- seek approval for the deferment of the Quality Framework audit, due to significant overlap with the current work programme of Audit Wales, with a replacement audit of the complaints (Putting Things Right) process to be completed;
- seek approval for the deferment of the Urgent Care System audit due to significant overlap with the current work programme of Audit Wales, with a replacement audit to be determined; and
- provide an overview of other activity undertaken since the previous meeting.

2. Progress against the 2022/23 Internal Audit Plan

There are 30 individual reviews in the 2022/23 Internal Audit Plan plus two reported from 2021/22, and provision for follow-up work (including time available for Medical Devices and Equipment if required).

The table below details progress against the 2022/23 Internal Audit Plan.

Number of audits in plan (including 2 from 2021/22):	32
Number of audits reported as final	8
Number of audits reported as draft	6
Number of audits work in progress	3
Number of audits at planning stage	10
Number of audits not started	5

The following final reports have been issued since the meeting of the Audit, Risk and Assurance Committee on 6 October 2022:

AUDIT ASSIGNMENT	**ASSURANCE RATING**
Clinical Audit	Limited
Digital Benefits Realisation	Substantial
Decarbonisation	N/A - Advisory

Further information over the assurance ratings detailed above is included with Appendix B.

We will also provide a verbal update over the draft outputs from Neighbourhood Care Networks audit, which is currently rated as reasonable assurance.

3. Summary of Findings

Limited assurance reports are considered by the Audit, Risk and Assurance Committee in detail. The following summary provides the Committee with the main messages from the substantial, reasonable, and advisory reports issued since the last meeting on 6 October 2022.

Clinical Audit (limited assurance)

This audit was rated limited assurance and will be considered separately by the Committee. However, we raised the following recommendations:

- A Clinical Audit Strategy should be fully implemented, with the draft that is available requiring significant review.
- There is no local clinical audit plan. Therefore, the Health Board cannot effectively plan to complete audits in areas with the greatest risk. Audits that should be completed may go unidentified, leading to additional clinical risks.
- There is limited tracking / monitoring of actions raised and the delivery of clinical audits.

Digital Benefits Realisation (substantial assurance)

We sought to ensure that the organisation has an appropriate framework and process in place for the achievement of benefits from investment in digital solutions.

We found that a comprehensive benefits framework has been developed and is being implemented, which covers all aspects of the benefit management process. However, we did recommend that the benefits associated with national programmes are considered holistically and alongside local programmes, to enable prioritisation. We also suggested improvement with the reporting processes for benefits.

Decarbonisation (advisory review)

The Welsh Government is party to international agreements to reduce carbon emissions and control climate change, most notably those arising from the 2016 Paris Accord. The NHS Wales Decarbonisation Strategic Delivery Plan was published in March 2021, setting interim targets (from a 2018/19 base) of a 16% reduction by 2025 and a 34% reduction by 2030.

However, as agreed during October's Audit, Risk and Assurance Committee, we have recognised that the process is still at an early stage of implementation. Therefore, we have reported on key themes identified through our review of Decarbonisation.

In particular, whilst some progress has been observed, this has been restricted by the availability of financial and staff resource. The recommendations made aim to aid management in driving forward the strategies, whilst also highlighting some of the competing pressures / risks.

4. Change of Planned Audit Reviews

We regularly liaise with Audit Wales to avoid work duplication and to identify emerging risks and themes. We had planned to complete an audit of the Urgent Care System and a separate audit of the Quality Framework. However, the scope of our planned work overlaps considerably with the planned work for Audit Wales.

Therefore, we are seeking **approval** for the deferral of the Quality Framework audit, which will be replaced by a review of the complaints (Putting Things Right) process.

We are also requesting **approval** for the deferral of the Urgent Care System audit, where a replacement audit is still be determined.

5. Other Activity

The following meetings have been held/attended during the reporting period:

- monthly meetings with the Director of Corporate Governance;
- monthly meetings with the Director of Finance, Procurement and Value;
- Audit, Risk and Assurance Committee pre-meeting with the Audit, Risk and Assurance Committee Chair;
- review and advice over financial control procedures; and
- liaison with senior management.

6. Recommendation

The Audit, Risk and Assurance Committee is invited to note the above and approve the changes to the Audit Plan.

Appendix A: Progress against 2022/23 Internal Audit Plan

Review	Status	Rating[1]	Summary of recommendations	Anticipated ARA Committee
Risk Management	Not started			May
Corporate Governance (Policy Management)	Work in progress			May
Financial Sustainability	Planning			February
CF - Care Closer to Home	Work in progress			February
Clinical Audit	Final Report	Limited	3 High, 3 Medium, 1 Low Priority	December
Urgent Care System (replacement not confirmed)	Not started			May
Access to Primary Care	Merged with NCNs audit			February
Neighbourhood Care Networks (NCNs)	Draft Report	Reasonable		
Mental Health Transformation	Planning			February
Dementia Services	Planning			May
Infection Prevention and Control	Planning			May
Use of off-contract Agency	Draft Report			February
Quality Framework (replaced by Complaints Management)	Planning			May
Discharge Planning	Draft Report			February
Integrated Wellbeing Networks	Planning			February
Agile Delivery	Final Report	N/A	1 High, 3 Low Priority	October
Review of Bank Office and Temporary Staff	Not started			May

[1] Subject to change on draft reports

Review	Status	Rating[1]	Summary of recommendations	Anticipated ARA Committee
Job Evaluation Process	Final Report	Reasonable	1 Medium, 1 Low Priority	October
Monitoring Action Plans	Not started			May
Follow-up of High Priority Recommendations	Not started			May
Digital Benefits Realisation	Final Report	Substantial	1 Medium, 1 Low Priority	December
Cyber Security	Planning			May
Records Management	Draft Report			February
Management of the Robotic Process Automation (RPA)	Draft Report	Reasonable		February
IT Strategy	Work in Progress			Febuary
Decarbonisation	Final Report	N/A	11 Matters arising	December
Tredegar Health and Wellbeing Centre	Planning			February
GUH	Final Report	Substantial	1 Low Priority	N/A
Integrated Audit Plans – YYF Breast Care Services	Draft Report	Reasonable		February
Integrated Audit Plans – Newport East	Planning			May
Integrated Audit Plans – Satellite Radiotherapy Centre	Planning			May
From 2021/22 Internal Audit Plan				
Children and Young People's Continuing Care	Final Report	Reasonable	1 High, 2 Medium, 4 Low Priority	October
Waste Management	Final Report	Reasonable	10 Medium, 1 Low Priority	August
Medical Equipment and Devices	Timing of audit to be assessed from quarter three onwards			

Appendix B: Audit Assurance Ratings

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

 **Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Digital Benefits Realisation
Final Internal Audit Report

November 2022

Aneurin Bevan University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Contents

Review reference:	ABUHB-2223-21
Report status:	Final
Fieldwork commencement:	19th July 2022
Fieldwork completion:	25th October 2022
Debrief meeting:	N/A
Draft report issued:	7th November 2022
Management response received:	23rd November 2022
Final report issued:	23rd November 2022
Auditors:	Martyn Lewis, IT Audit Manager Kevin Bridgman, IT Audit Manager
Executive sign-off:	Nicola Prygodzicz, Chief Executive
Distribution:	Mike Ogonovsky, Chief Digital Officer Janice Jenkins, Interim Assistant Director of Digital Programmes
Committee:	Audit, Risk and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the 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.

Executive Summary

Purpose

To consider whether the organisation has an appropriate framework and process to ensure that benefits are gained from investment in digital solutions.

Overview

We have issued substantial assurance on this area.
A new, comprehensive benefits framework has been developed and is being implemented which covers all aspects of the benefit management process.
The matters requiring management attention include:

- Ensuring that benefits associated with national programmes are considered holistically with local programmes to enable prioritisation.
- Improving the reporting processes for benefits.

Report Opinion

Substantial

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

Low impact on residual risk exposure.

Assurance summary[1]

Objectives		Assurance
1	Benefits Framework	Substantial
2	Benefit Focussed Business Cases	Substantial
3	Benefits Realisation	Substantial

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

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	National Programme Benefits	2	Design	Medium
2	Reporting on Benefits	3	Operation	Low

1. Introduction

1.1 In line with the 2022/23 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board') a review of the processes in place for ensuring that the benefits associated with the implementation of digital solutions has been undertaken.

1.2 Benefits realisation is the definition, planning, structuring and actual realisation of the benefits of a business change or digital implementation project.

1.3 Projects are often considered finished when their deliverables are complete. However, the benefits of a project are typically realised over time. For benefits realisation to work it is crucial to identify clear benefits (early in the change lifecycle) and to assign ownership to those responsible for planning and managing their achievement.

1.4 The risk considered as part of this audit is investment in digital solutions does not produce the anticipated benefits to the organisation

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	1	-	1
Operating Effectiveness	-	-	1	1
Total	-	1	1	2

Objective 1: Benefits Realisation Framework: A framework for benefits realisation is in place which defines how benefits should be owned identified, structured, planned and realised.

2.1 The Aneurin Bevan Business Change and Benefits Team within Informatics has produced a comprehensive Benefits Management Framework for use within the organisation. This sets out the framework and documentation to manage projects and programmes in terms of benefit delivery. The framework identifies the timeline for benefits and the tools to be used to ensure the benefits are fully realised.

2.2 The Benefits Management Framework (the 'Framework') sets out the processes by which benefits will be managed throughout the business change lifecycle. The framework clearly defines the benefits management lifecycle and ensures benefits are identified within business cases, with an established baseline, and that owners are clearly identified for each benefit. The key points covered within the framework are:

- the purpose of benefits management;

- the approach being taken to benefits planning, which includes how benefits will be identified, defined, and prioritised;
- the roles and responsibilities of those involved in benefits planning and benefit realisation;
- identifying when and how reviews and assessments concerned with measuring benefit realisation will be conducted, and who will be involved;
- measurement methods and steps that will be used to monitor and assess the realisation of benefits; and
- the tools, systems and sources of information that may be used to enable benefit measurement.

2.3 A Benefits Toolkit has been produced to support the Framework to ensure a consistent approach is used across the organisation. The toolkit is used to map the benefits profile for each benefit and execute the benefits realisation plan.

2.4 We note that digital projects are supported by internal Business Change Managers which enable greater confidence over the ability of the organisation to realise the benefits associated with digital solutions.

2.5 The framework also provides guidance on the management of potential dis-benefits associated with digital solutions so that these can be kept under review and actively mitigated, and this influences future business change activity.

2.6 The framework and toolkit enable engagement with the service owners to develop guides for their departments. There is an implementation process from the inception of the project, making use of workshops and engagement with service owner where benefits are explained, linking into KPIs for the service where applicable.

Conclusion:

2.7 The Health Board has recently developed a comprehensive benefits management framework with a supporting toolkit, which enables the organisation to fully track benefits from inception to realisation. Accordingly, we have provided substantial assurance for this objective.

Objective 2: Benefits Focused Business Case - Business cases show the value that projects or programmes will achieve by the proposition in the business case, by identifying specific benefits that will be achieved, with the current position being baselined.

2.8 Business cases are developed in order to obtain finance for programmes. These set out the justification for the programme and include the anticipated benefits that will be delivered in return for the investment.

2.9 In general, there are two sources for business cases development. These are locally defined programmes which directly fall out of Health Board strategic plans, and national programmes.

2.10 We note that locally defined programmes contain benefits that are more directly linked to the Health Board's objectives and better defined within the Health Board's structure.

2.11 For national programmes, there is no automatic funding provided and so business cases are developed, which include a translation of the benefits defined within the national business case into a local business case. We note that benefits within national business cases are sometimes at a very high level, and as such the Informatics team filters out what is beneficial to the Health Board.

2.12 We note that national business cases sometimes make assumptions that all NHS organisations work in the same way. We further note that the benefits from national programmes may not be fully achievable for the Health Board, however the processes to feedback and re-prioritise national programmes are not yet fully defined. We note that work is ongoing on the "Front of House" process which will help resolve this issue. **See matter arising 1**

2.13 We note that the use of the new toolkit and workshops with stakeholders enables business cases to be created with benefits that are realistic and measurable. This also enables the ownership of benefits moving away from Informatics to the department who will benefit from the project.

2.14 Our review of the Careflow business case confirmed that the benefits contained within the business case were supported by backing information and the values stated were reasonable. We further note that the baseline position for Careflow was established prior to project go-live.

2.15 We note that the new Framework better enables the production of benefits focussed business cases, as the requirements for benefits definition are explicitly covered within the Framework.

2.16 The Framework sets out that a benefits management strategy should be developed that informs the business case, with the key points being:

- the high level benefits the project is designed to achieve;
- approach to benefits mapping;
- the process by which benefits will be managed;
- the high-level arrangements for managing threats to benefits;
- governance arrangements for managing threats to benefits; and
- definition of roles and accountabilities.

2.17 We further note that the Framework required that both benefits discovery workshops and benefits quantification workshops will be undertaken prior to the business case being developed.

2.18 The introduction of the benefits framework and toolkit has coincided with the re-invigoration of the Careflow project. As part of this, the benefits associated with Careflow are being re-visited and reassessed to ensure that they are still valid, and where additional or amended benefits can be identified. The new process ensures greater stakeholder participation in benefits definition and so the benefits as defined will be more reliable.

Conclusion:

2.19 There are strong processes for the development of business cases, and the Framework enables greater focus on realistic benefits within business cases. The Framework also ensures ownership of benefits and provision of a baseline and measurement process at the outset. Accordingly, we have provided substantial assurance for this objective.

Objective 3: Benefit Realisation – benefits are tracked, and the structure ensures that these are achieved, with actions taken if they do not accrue.

2.20 Benefits realisation is the practice of ensuring that benefits are derived from outputs and outcomes. The Business Change Team engages with departments to ensures the benefits are realistic and achievable. This ensures 'buy in' and shows commitment to the project.

2.21 The Business Change team has enacted good practice from MSP (managing successful programme), with the Business Change manager overseeing the realisation of the benefits.

2.22 Alongside engagement with the identified benefits owners, the toolkit enables the benefits realisation process, with it being used to assess the progress of the project against the baseline. This will identify any gaps in the project, allowing the team to look at mitigating circumstances.

2.23 We note that the use of the toolkit alongside the business change process helps support the recipients of the benefits through the implementation process culminating in the handover of the project to the department. This will ensure that benefits are continued to be measured and realised after the business change cycle has ended, as some benefits may take several of months to be realised.

2.24 We reviewed the benefits realisation process associated with the Careflow programme, the implementation of which has not been fully completed. We note that the benefits contained within the business case do not fully map across to the current benefits spreadsheet due to the business case being developed before the updated benefits process was in place.

2.25 As part of the work to re-invigorate the Careflow Programme, there has been work undertaken to reconsider the benefits associated with the programme and restate these to ensure they provide a more accurate benefit statement. This work is re-embedding the benefits realisation process and we note that the revised spreadsheet gives a more accurate view of the benefits realisations program.

2.26 Our work confirmed that the benefits within the Careflow programme each have a benefits owner from the service and a mechanism to measure the delivery of the benefit. As part of the ongoing work the benefits team is working with the service to ensure the benefit is still appropriate and achievable.

2.27 The risks associated with the achievement of benefits are contained within the toolkit, and where benefits are not being realised according to plan, the toolkit clearly contains the actions to be undertaken in order to correct this.

2.28 Progress against benefits realisation plans is monitored by the business change manager and reporting on benefits realisation is to programme boards.

2.29 We note that a report was produced for the Audit, Risk and Assurance Committee in February 2022 on the benefits realised from digital solutions within the Health Board. We have been informed that this is to be a six-monthly report, however no subsequent report has been noted.

2.30 We also note that a dashboard is being developed to enable easy reporting and visualisation of the Framework. **See matters arising 2.**

Conclusion:

2.31 The toolkit enables a comprehensive benefits realisation framework, with each programme incorporating a benefits plan. Benefits are owned by the service and non-achievement is monitored, and remediating actions defined. There is reporting on benefits within programmes and reporting to the Audit, Risk and Assurance Committee has commenced. Accordingly, we have provided substantial assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: National Programmes (Design)			Impact
National business cases sometimes make assumptions that all NHS organisations work in the same way and therefore a level of scrutiny is applied to national projects. Benefits from national programmes may not be fully achievable for the Health Board. However, the processes to feedback and re-prioritise national programmes, within the ABUHB workplan, are not yet fully defined. We note that work is ongoing on the "New Digital Service Request" process which will help resolve this issue			Potential risk of: • Having to use internal funding on a project with little or no benefits to the Health Board
Recommendations			**Priority**
1.1	The Health Board should finalise the "front of house" process and enable a process for a holistic prioritisation of programmes.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	A draft New Digital Service Request (NDSR) process has been designed to provide transparent onboarding of new work for the informatics directorate. The process sets out how Informatics undertakes and supervises a workflow using agreed standard tools and documentation from triage, through evaluation, discovery & definition to transition to programmes or Service Delivery. This will provide internal assurance of the process and ensures that options are presented to Digital Delivery Oversight Board (DDOB) with a clear assessment of priority and	Q1 23/24 (By June 2023)	Mike Ogonovsky / John Frankish

	recommendations. DDOB is the body that will make informed decisions on the prioritisation of Informatics programmes and projects. New national programmes will be tracked through the same process allowing the Health Board to locally prioritise and feedback these priorities back to national. This draft process needs to be signed off and fully implemented.		

Matter Arising 2: Reporting (Operation)			Impact
A summary report on benefits associated with digital solutions was provided to the Audit, Risk and Assurance Committee during February 2022. However, this has not been repeated since. We also confirmed that development of a dashboard, to visually show the benefits, is in progress.			Potential risk of: • Department not taking ownership and no visual display of benefits.
Recommendations			**Priority**
2.1	The Health Board should continue with an annual reporting cycle that summarises the benefits position for the Audit, Risk and Assurance Committee. Work on the benefits dashboard should be completed and incorporated into future reporting.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Benefits updates are provided at monthly programme boards and quarterly to Programme Delivery Board (PDB). Work is ongoing with the PMO using the informatics portfolio register to develop oversight of portfolio level benefits. A local dashboard is under development for summary reporting to DDOB on a six monthly basis. This dashboard can be updated to provide an annual update to the Audit, Risk and Assurance Committee.	Q2 23/24 (By Sept 2023)	Mike Ogonovsky / Janice Jenkins

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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Decarbonisation Final Report

November 2022

NWSSP Audit and Assurance Services

Contents

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Committee:	Audit, Risk and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the 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.

1. Context

1.1 The Welsh Government is party to international agreements to reduce carbon emissions and control climate change, most notably those arising from the 2016 Paris Accord.

1.2 The "NHS Wales Decarbonisation Strategic Delivery Plan" was published in March 2021, setting interim targets (from a 2018/19 base) of a 16% reduction by 2025 and a 34% reduction by 2030.

1.3 In October 2021 the Welsh Government set out its second carbon budget, Net Zero Wales, which confirmed:

> "Our ambition is for the public sector to be collectively net zero by 2030".
>
> *Welsh Government, October 2021*

1.4 NHS Wales is also required to comply with the Well-being of Future Generations (Wales) Act 2015. It requires public bodies in Wales to think about the long-term impact of their decisions, to work better with people, communities, and each other, and to prevent persistent problems such as poverty, health inequalities and climate change.

2. Background

2.1 In accordance with the "NHS Wales Decarbonisation Strategic Delivery Plan", Health Boards, Trusts and Special Health Authorities were required to develop their own Decarbonisation Action Plans (DAP), demonstrating how NHS Wales organisations would implement the Strategic Delivery Plan initiatives. The DAP's were submitted to Welsh Government in March 2022.

2.2 A peer review of DAP strategies was held on 12 July 2022 led by Welsh Government and attended by all NHS Wales organisations. The general conclusions across all plans were:

- the targets detailed within the plans showed low aspirations;
- there were concerns associated with their successful delivery, primarily due to resource availability (financial and physical); and
- there were a small number of issues associated with their compilation/format.

2.3 Specific feedback was also provided to each organisation by Welsh Government.

2.4 Also in July 2022, Audit Wales issued their review of Public Sector Readiness for Net Zero Carbon by 2030 (fieldwork conducted between November 2021 and January 2022). The review included an assessment of NHS Wales organisations and concluded that:

> "There is clear uncertainty about whether the public sector will meet its 2030 collective ambition. Our work identifies significant, common barriers to progress that public bodies must collectively address to meet the ambition of a net zero public sector by 2030. And while public bodies are demonstrating commitment to carbon reduction, they must now significantly ramp up their activities, increase collaboration and place decarbonisation at the heart of their day-to-day operations and decisions".
>
> *Audit Wales, July 2022*

2.5 In September 2022, Health bodies will be required to make two separate submissions to Welsh Government, the first of these being quantitative (i.e., showing progress against the baseline $C0_2$ figures set in 2019) and the second qualitative, being a report detailing progress against the DAP.

3. Approach

3.1 Audits were planned to be undertaken simultaneously across NHS Wales to provide assurance to respective NHS Wales bodies on their arrangements to reduce carbon emissions and control climate change as outlined above. Reviews were not scheduled at Public Health Wales or Health Education and Improvement Wales for 2022/23.

3.2 Risks to be considered included:

- Regulatory/legislative risk through not achieving mandated reductions in carbon emissions;
- Reputational risk by failing to meet emission targets.
- Failing key stakeholders by not reducing carbon emissions which have a detrimental effect on health, and thereby, not meeting the requirements of the Well-being of Future Generations (Wales) Act (2015).

3.3 Having reviewed all DAPs, supporting information for most NHS Wales bodies and fully concluding the fieldwork at five of 11 audits, it was clear that in each instance the implementation plans had not been sufficiently developed to allow meaningful testing and to provide an assurance rating to respective Audit Committees.

3.4 Accordingly, the decision was taken to affirm common themes within this report, to provide an overview of the overarching position across NHS Wales. An action plan of common themes is provided at **Appendix A.**

4. Summary Observations

4.1 While there are variations between the NHS Wales bodies, broadly each is at an early stage of implementation. The following were common themes observed across those reviewed:

Governance

- Governance arrangements at a strategic level were generally good with senior leadership demonstrated.
- Recruiting to additional operational posts has proven difficult – with the limited appointments to date coming from the existing public sector staff pool. These appointments are key to being able to implement the agreed strategies (see **Management Action 1**).

Localised strategy

- All NHS Wales organisations supplied their Decarbonisation Action Plan (DAP) by 31 March 2022 detailing their response to the NHS Wales Decarbonisation Strategic Delivery Plan and the 46 associated initiatives.
- WG provided positive feedback to each organisation on their submissions but concluded overall that there were concerns associated with their successful delivery (primarily due to the availability of financial and physical resource), together with low aspirational targets detailed within the plans.
- Few of the strategies had been costed, and none had associated funding strategies – particularly noting that ring-fenced central funding for 2021/22 was £16m with no provision made in 2022/23 (see **Management Actions 2 & 3**).
- In each instance, the decarbonisation strategies were clearly part of corporate planning and included/reflected within the respective Integrated Medium-Term Plans (IMTPs).

Monitoring & reporting

- Organisations were ISO 14001 accredited ensuring that appropriate Environment Management Systems were in place to manage their environmental performance.
- Each NHS Wales organisation's performance will be assessed against baseline data prepared by the Carbon Trust. Issues have been identified with the baseline data and the disaggregation of the data for reporting purposes. Each organisation should seek assurance on the accuracy of the baseline data (see **Management Action 4**).
- Each NHS Wales organisation should ensure that appropriate engagement is established with NWSSP Procurement Services as a significant contributor to the carbon reductions outlined within respective DAPs and formalise arrangements as appropriate (see **Management Action 5**).

- Each organisation had met its obligations for national reporting to date.
- Internal reporting to date had understandably been limited, with the level of reporting increasing after Welsh Government's review of the DAPs.
- There was therefore a need to fully roll-out the structures to support appropriate monitoring and reporting within the NHS Wales organisations reviewed (see **Management Action 6**).
- It is important that the profile of decarbonisation is increased to reflect the challenge faced, for example general Terms of Reference are reviewed to reflect decarbonisation commitments, and decarbonisation is set as a standard agenda at all appropriate Executive meetings (see **Management Action 7**).
- Potential collaboration should be considered on an All-Wales basis, particularly in relation to consultancy advice and training resource (see **Management Actions 8 & 9**).

Project delivery

- The Welsh Government Estates Funding Advisory Board (EFAB) oversaw the allocation and delivery of the £16m decarbonisation funding for 2021/22 with each NHS Wales organisation successfully securing funding.
- In each instance, adequate records were retained to support the expenditure and the achievement of the original objectives; Post Project Completion Reports were produced and submitted to WG for all funded schemes.
- No ring-fenced WG capital funding was made available for 2022/23. WG offered up to £60k of revenue funding for schemes, however several NHS Wales organisations' bids could not be supported due to them being considered capital bids (see **Management Action 10**).
- NHS Wales Organisations were also self-funding initiatives from their discretionary programme. It is important that the cost benefit of these schemes is also subject to challenge and scrutiny for inclusion within the overall data (see **Management Action 11**).

5. Conclusion

5.1 In conclusion, whilst some progress has been observed, this has been restricted by the availability of financial and staff resource. The recommendations made aim to aid management in driving forward the strategies, whilst also highlighting some of the competing pressures/ risks.

5.2 It is recommended that an audit is scheduled for early 2023/24 with the proposed scope to include governance, strategy progress and implementation.

5.3 Additionally, as part of 2023/24 Internal Audit planning update, discussions will be held with management on the appropriateness of other areas within the decarbonisation programme including, for example:

- Procurement and supply chains.
- Application of "Best practice Pharmaceutical waste practice".
- Transport.
- Fleet and business travel.
- Staff, patient and visitor travel.
- Catering; and
- People and workforce e.g., training, policies, and working arrangements.

Appendix A: Common Management Action Plan

Ref.	Recommendation	Management Comment/ Agreed Action	Responsible Officer/ Deadline
MA 1	Appropriate strategies should be developed to ensure that recruitment and retention issues experienced to date do not impact significantly on the achievement of the DAPs.	Agree. We shall continue to review the roles required to implement the DAP objectives and ensure effective succession planning is in place. Directly relating to Initiative 9 – Facilities Division has recently appointed a dedicated Building Management System (BMS) Officer (due in post Jan23). Through an Academy Wales graduate development programme we shall be utilising a student placement to assist with decarbonisation metrics, reporting and	Workforce & Organisational Development Business Partner Accountant Interim Facilities General Manager TIMESCALE: NOVEMBER 2023

Ref.	Recommendation	Management Comment/ Agreed Action	Responsible Officer/ Deadline
		engagement starting in 23/24	
MA 2	DAPs should be fully costed to fully determine the total funding required.	Action Noted. Sub-groups of the main DPB have been tasked with developing action plans relating to their delegated national initiatives. This work will include costing projects and is currently in progress. Programme/project costs to meet the interim CO2 reduction targets are currently being analysed	Assistant Director Finance TIMESCALE: 2022/23 QUARTER 4
MA 3	DAPs should be supported by funding strategies e.g. differentiating between local/ national funding, revenue or capital funding etc.	Agree. Projects developed through the DAP shall be funded appropriately – ReFit, HSC, EFAB,	Decarbonisation Programme Board (DPB) Workstream Leads

Ref.	Recommendation	Management Comment/ Agreed Action	Responsible Officer/ Deadline
		revenue, discretionary capital	TIMESCALE: NOVEMBER 2023
MA 4	NHS Wales Organisation's baselines should be adequately scrutinised and challenged, as errors and overreporting has been identified in a few examples to date.	Agree. Net Zero Report data sources, analysis and report generation will be subject to an internal review. The HB have now set up a Decarbonisation Programme Board which incorporates the existing metrics along with additional scrutiny of new projects coming on line within the working groups.	Energy & Carbon Manager DPB Workstream Leads TIMESCALE: DEC22 TO MAY23
MA 5	As a major contributor to the achievement of the targeted reductions appropriate engagement will be established with NWSSP Procurement Services (and formalised as appropriate).	Agree. The DPB have requested suitable NWSSP Proc Serv. Representation at meetings to update and provide guidance	Asst. Director Finance & Finance & Resources Workstream Lead TIMESCALE: NOVEMBER 2023

Ref.	Recommendation	Management Comment/ Agreed Action	Responsible Officer/ Deadline
		and feedback on progress. Within the programme governance arrangements we have identified **four** task and finish working groups who will link with our local procurement team. In addition we also have a financial representative leading group 4 who directly links in with health board Director of NWSSP National initiatives which are reported at the Bi-monthly board meetings within the health board.	
MA 6	Proposed management/accountability structures should be fully implemented as intended within the DAPs.	Agree. Appropriate governance structures for the DPB and	DPB & Workstream Leads

Ref.	Recommendation	Management Comment/ Agreed Action	Responsible Officer/ Deadline
		subsequent workstreams have been established with ToRs for both DPB and workstreams complete	TIMESCALE: COMPLETE WITH PERIODIC REVIEW
MA 7	Where decarbonisation falls within the existing environmental remit of committees/ meetings, it is important that an appropriate profile is set. Terms of Reference and agendas should be reviewed to ensure that sufficient focus is provided.	Agree. The Decarbonisation Programme Board (DPB) within its structure has 4 sub-groups each with national initiatives delegated to them. The DPB and sub-groups each have ToR's and scheduled meeting frequencies	Decarbonisation Programme Board Workstream Leads TIMESCALE: NOVEMBER 2023 AND SUBJECT TO PERIODIC REVIEW
MA 8	Potential collaboration and common utilisation of decarbonisation resource should be considered on an All-Wales basis, particularly in relation to consultancy advice and training resource.	Agree. ABUHB & PTHB are currently collaborating on Biodiversity Assessments funded	Energy & Carbon Manager TIMESCALE: END MAR 2023

Ref.	Recommendation	Management Comment/ Agreed Action	Responsible Officer/ Deadline
		through HSC Climate Emergency Fund	
MA 9	In accordance with the NHS Wales Decarbonisation Strategic Delivery Plan, HEIW/ collaborative training should be commissioned on an All-Wales basis to provide both common and tailored decarbonisation training.	Agree. SusQI training has been rolled out to relevant officers. ABUHB would support the development of an All-Wales training package	DPB & Head of Communications & Comms/Training/Digital Workstream Lead
MA10	Given the scarcity of funding, it is important that bids for funding are appropriately considered prior to submission.	Agree. Funding submissions are suitably scrutinised by appropriate forums e.g. Pre-Investment Panel (PIP), Capital Programme Board or DPB	DPB & Workstream Leads TIMESCALE: NOVEMBER 2023
MA11	The same rigour and monitoring should be applied to internally commissioned/ funded initiatives to ensure the outcomes are adequately recorded/reported.	Agree. Projects shall be reported to the DPB with adequate metrics developed to measure carbon reduction potential. Such projects will also	Workstream Project Leads TIMESCALES: NOVEMBER 2023

Ref.	Recommendation	Management Comment/ Agreed Action	Responsible Officer/ Deadline
		be reported to WG through the bi-annual qualitative reporting requirements	

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Clinical Audit
Final Internal Audit Report

November 2022

Aneurin Bevan University Health Board

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

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Contents

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Distribution:	James Calvert, Medical Director Leeanne Lewis, Assistant Director for Quality and Patient Safety Joanne Stimpson, Quality and Patient Safety Lead for National Clinical Audit
Committee:	Audit, Risk and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the 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.

Executive Summary

Purpose

The audit was undertaken to review the process for delivering clinical audits, including how they are used by the Health Board to support assurance.

Overview

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

- A Clinical Audit Strategy should be fully implemented, with the draft that is available requiring significant review.
- There is no local clinical audit plan. Therefore, the Health Board cannot effectively plan to complete audits in areas with the greatest risk. Audits that should be completed may go unidentified, leading to additional clinical risks.
- There is limited tracking / monitoring of actions raised and the delivery of clinical audits.

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

Report Classification

		Trend
Limited 	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	⇔

Assurance summary[1]

Assurance objectives		Assurance
1	Clinical Audit Strategy	Limited
2	Local clinical audit plan	Limited
3	National clinical audit plan	Reasonable
4	Future planning	Limited
5	Follow-up of previous recommendations	Limited

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Clinical Audit Strategy	1, 2	Design	High
2	Local clinical audit plan	2, 4	Design	High
3	National clinical audit results	3, 4	Design	Medium

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

1. Introduction

1.1 A review of Clinical Audit was completed in line with the 2022/23 internal audit plan. The review sought to provide Aneurin Bevan University Health Board (the 'Health Board') with assurance that there are effective processes in place to manage local and national clinical audit plans.

1.2 The risks considered as part of this review were:

- Inappropriate governance structure / arrangements in place.
- Lack of a clinical risk register or identification of relevant risks.
- Failure to have an effective reporting pathway for clinical audit results.
- Failure to act upon the results of clinical audits.
- Failure to participate in the NHS Wales National Clinical Audit and Outcome Review.
- Clinical audits do not provide sufficient assurance to the Board over the management of associated risk.
- Internal audit recommendations are not implemented.

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	3	3	1	7
Operating Effectiveness	-	-	-	-
Total	3	3	1	7

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

Audit objective 1: There is an approved clinical audit strategy and clinical risk register in place.

2.3 The Health Board has a draft Clinical Audit Strategy (the 'Strategy') setting out its vision for clinical audit for 2022-2025. The Health Board has four priorities regarding clinical audit, these are:

- There is scrutiny of National Clinical Audit performance with robust development, monitoring, and progression of improvement plans.
- Divisions to identify clinical audits that allow scrutiny and assurance associated with quality and safety risk.
- Trainees are supported to participate in meaningful clinical audits that support clinical governance.

- Groups and committees across the Health Board will commission clinical audit to support effective assurance where no other evidence is available.

2.4 The Strategy includes actions to implement the four priorities, however, many of these actions remain outstanding. There is also no clear plan to implement these actions. **Matter arising 1.**

2.5 It was noted, within a report sent to the Patient Quality, Safety and Outcomes Committee (PQSOC), that issues identified within clinical audits are included on the divisional risk register and a number of areas are also included within the covid and corporate risk registers.

2.6 However, there is no evidence that any checks are completed to ensure all remedial actions are included within these registers. There is currently no process in place to ensure the actions are assigned to an appropriate person and the Health Board does not complete spot checks to confirm actions are being completed in a timely manner. The Health Board places reliance on each division correctly identifying all necessary issues, adding them to their divisional risk registers and then monitoring them effectively.

2.7 Additionally, there is no evidence that the Health Board has considered whether it has the resource at an operational level to ensure clinical audit is carried out to a high standard and any resulting actions are implemented. This is also included within **matter arising 1.**

Conclusion:

2.8 The Health Board needs to formalise the Clinical Audit Strategy and consider whether it has given enough resources to those responsible for clinical audit to carry out the Strategy. Therefore, we have given this objective **limited assurance.**

Audit objective 2: An appropriate local clinical audit plan is developed, approved, with progress, conclusions and actions monitored by an appropriate forum / committee.

2.9 There is no local clinical audit plan in place. Until recently, there has been little governance over what local clinical audits have been completed. We were unable to be provided with a list of local clinical audits completed for the past year as this list did not exist. **Matter arising 2.**

2.10 However, going forward, the Quality and Patient Safety Lead for National Clinical Audit informed us local clinical audits have been requested to be added to the AMaT[2] application. This is the programme used to monitor and detail all information for any national clinical audits. This is in its infancy and there are currently only a very limited number of local clinical audits noted within the system. **Matter arising 2.**

[2] Clinical audit software title

2.11 As there is no local clinical audit plan, a reconciliation between what is on the plan and what is logged on AMaT cannot be completed.

2.12 Given the lack of plan and ability to review any local clinical audits, we were unable to completed testing for this objective.

Conclusion:

2.13 Given the absence of a local clinical audit plan, we have provided **limited assurance** for this objective.

Audit objective 3: Where applicable, the Health Board takes part in the Annual Programme, detailed in the NHS Wales National Clinical Audit and Outcome Review Plan.

2.14 The National Clinical Audit and Outcome Review Plan (NCAORP) is a mandated programme of national audit commissioned by the Health Quality Improvement Partnership (HQIP). It is designed to help assess the quality of healthcare and stimulate improvement in safety and effectiveness, by systematically enabling clinicians, managers and policy makers to learn from adverse events and other relevant data.

2.15 The Quality and Patient Safety Lead for National Clinical Audit confirmed that the Health Board participates in all audits where applicable (excluding any related to functions the Health Board does not carry out).

2.16 National clinical audits and their results are added to the AMaT system (which is also used across Wales). A review of the system confirmed that national clinical audits from the national plan are being recorded and used to effectively maintain clinical audit information.

2.17 However, during interviewing we found that there is no deadline by which each audit has to be completed. This sometimes leads to difficulty in obtaining participation from some divisions, particularly where staffing resources may be an issue. We could not therefore confirm whether each audit was completed in a timely manner as this information is not tracked. **Matter arising 3**.

2.18 The AMaT system is straightforward to use, and there is an AMaT user guide available, but this is not held on the intranet. **Matter arising 4**.

Conclusion:

2.19 National Clinical audits are being completed and results noted in an effective system. Therefore, we have provided **reasonable assurance** for this objective.

Audit objective 4: Results of all clinical audits undertaken are triangulated and inform future planning.

2.20 Following the publication of each national clinical audit, the Clinical Lead, in conjunction with the Divisional Director, reviews the reports and develops an action plan to address any requisite improvements. Both results and action plans

are presented to the Health Board's Clinical Standards and Effectiveness Group (CSEG) which reports to Quality and Patients Safety Operational Group - a subgroup of the PQSOG.

2.21 Minutes from both groups confirmed actions are discussed at the CSEG meetings along with a summary of each audit undertaken presented by the designated clinical lead for that area. An update report is presented to PQSOC, most recently going in August 2022, which discussed in detail each of the audits.

2.22 Local clinical audits are not discussed at any forum. There is no evidence that the actions from these audits are monitored and there is no clear escalation process if actions identified as part of the audit require further investigation. **Matters arising 1 and 2.**

2.23 We were not presented with evidence that national clinical audits inform the Health Board's future planning or that actions raised are monitored and tracked. We were informed that there are plans to put all actions raised through national clinical audits onto AMaT so they can be tracked. This has not yet been completed. Clinical audit is only mentioned briefly in the Health Board's Integrated Medium-Term Plan (IMTP). **Matter arising 3**.

Conclusion:

2.24 There is evidence of oversight of the national clinical audit plan. However, there are still weaknesses in the tracking of actions raised and little evidence that the audits affect the Health Board's future planning. Therefore, we have provided **limited assurance** for this objective.

Audit objective 5: A review on the progress / completion of previous audit recommendations raised.

2.25 As part of this audit, we undertook a review of the progress / completion of previous audit recommendations raised within the 2018/19 Clinical Audit internal audit report. Three recommendations were raised within this report. During the 2019/20 financial year a follow up of the recommendations within the 2018/19 report was undertaken. The remaining outstanding actions from each of the three recommendations are noted below, and an updated position has been added.

2.26 **Recommendation 1 – Quality & Patient Safety Assurance Framework**

Actions relating to this audit noted in the 2019/20 report:

- Completion of the development of the QPS Strategy & Assurance Framework; and
- Assessment of the level of clinical audit required by the Health Board.

This recommendation has been **fully superseded** by recommendations one and two below.

2.27 **Recommendation 2 - Clinical Audit Framework**

Outstanding actions noted with in 2019/20 report:

- The update of the Clinical Audit Strategy & Policy remains contingent on the completion of outstanding actions identified in this report and has an implementation target date of June 2020.

This recommendation has been **fully superseded** by recommendation one below.

2.28 **Recommendation 3 – Divisional Clinical Audit**

Outstanding actions noted with in 2019/20 report:

- Completion of the development of the divisional QPS assurance frameworks; and
- Monitoring against the divisional QPS assurance frameworks at the CESG meetings.

This recommendation has been **fully superseded** by recommendations three and four below.

2.29 The Covid-19 pandemic has delayed the Health Board's improvement of Clinical Audit and its implementation of actions raised during the 2019/20 internal audit. Actions still remain outstanding and to continue to improve the clinical audit process these should be implemented as soon as possible.

Conclusion:

2.30 Little progress on the implementation of previous recommendations has been noted, therefore we have given this objective **limited assurance**. However, these recommendations have been superseded by the current matters arising within appendix A and recorded as such.

Appendix A: Management Action Plan

Matter arising 1: Clinical Audit Strategy (Design)	Impact
The Health Board has a draft Clinical Audit Strategy (the 'Strategy') setting out its vision for clinical audit for 2022-2025. The Health Board has four priorities regarding clinical audit. The Strategy includes actions to implement the four priorities, however, many of these actions remain outstanding. There is also no clear plan to implement these actions and parts of the strategy are yet to be completed.	Potential risk of: • Lack of assurance that statutory requirements have been considered and the necessary processes are in place. • Ad-hoc approach to clinical audit leading to reduced patient welfare.

Recommendations	Priority
1.1 Review and renew the Clinical Audit Strategy, which should include: • how the Health Board plans to track and monitor actions raised in national clinical audits; • the process for designing a plan for local clinical audits and what needs to be taken into consideration when creating a local clinical audit plan; • resourcing requirements to ensure both national and local clinical audits are effectively monitored; • role and responsibilities for clinical audit, including the monitoring groups; • how assurance is provided from each applicable divisions / directorates; and • the escalation process for actions raised within audits.	High

Management response	Target Date	Responsible Officer
1.1 The internal audit focused on two main parts of the clinical audit, firstly at how the health board participate in national clinical audits and then secondly its participation in local clinical audits. It has been highlighted that sample testing around the local clinical audits would have been undertaken but not possible at this time as the control framework around this area was not robust. However, it has been noted in the report that this is improving.	NA	NA - Information

The Clinical Audit Strategy was updated and published in Oct 2022. It provides the Strategic Direction for Clinical audit for the Health Board and sets out the commitment to quality and effectiveness through the application of clinical audit to support delivery of: High quality, patient safety, patient experience and clinical effectiveness.	Completed Oct 2022	Assistant Director QPS (Leeanne Lewis) / Quality and Patient Safety Lead for National Clinical Audit / Dr Leo Pinto
The strategy includes the requirement for Divisions and Corporate leads to develop Clinical Audits plans aligned to quality and safety risk with a key set of benchmarks to support this. The Divisional Triumvirates will be sighted on all relevant documents relating to Clinical Audit, as well as the Clinical Lead.	March 2023	Assistant Director QPS (Leeanne Lewis) / CSEG / Divisional Triumvirate
The newly purchased web-based Audit Management and Tracking (AMaT) system will allow audit to be more efficient. Standardised reports can be produced via AMaT, documenting success – areas where good practice has been identified, challenges – areas where practice requires improvement and an action plan with specific timeframes and nominated lead.	May 2023	Assistant Director QPS (Leeanne Lewis) / CSEG / Divisional Triumvirate
Using AMaT Clinical Directors will be empowered to undertake audits more effectively and enable presentation of data as a dashboard system and easy-to-read graphical presentations. This will improve engagement with the clinical directors, QPS audit team and Clinical Standards and Effectiveness Group (CSEG).	May 2023	Assistant Director QPS (Leeanne Lewis) / QPS Clinical Audit team/ Clinical Directors / CSEG
The QPS team will work in collaboration with Clinical Audit leads to utilise AMaT to its full capabilities. This will allow tracking of results and an action plan to be produced with measurable improvements within a specified timeframe.	May 2023	Assistant Director QPS (Leeanne Lewis) / QPS Clinical Audit team/ Clinical Directors / CSEG
ABUHB will facilitate the wider use of data from audit and national registries to be used as supporting information for medical revalidation and peer review. We will aim to create a report on audits in which individual ABUHB employed substantive doctors have participated and these being presented in doctors' annual appraisal. This would include a zero-return statement e.g. this doctor has not undertaken an audit this year.	March 2023	Assistant Director QPS (Leeanne Lewis) / Executive Medical Director / Assistant Medical Directors
Where ABUHB has been identified as an outlier on a national audit we will implement a SOP, which will ensure a standardised approach is undertaken in reviewing, investigating and responding to outlier notification in relation to national clinical audits.	March 2023	Assistant Director QPS (Leeanne Lewis) / CSEG / Executive Medical Director and Divisional Triumvirate

This will be undertaken by the audit clinical lead and be signed off by CSEG and a summary will be provided for the Exec team.		
The Terms of Reference for CSEG have been updated. CSEG oversees the governance relating to clinical audit and reports biannually to PQSOC the outcomes and improvements plans relating to national audit.	Completed	Assistant Director QPS (Leeanne Lewis) / Quality and Patient Safety Lead for National Clinical Audit / Dr Leo Pinto
A Quality Governance Day with Exec Leads, QPS, Risk and Governance and QI (ABCi) will take place with an aim to review the assurance framework for Committees and Operational Groups. This will review governance arrangements for reporting findings of clinical audit and consider the assurance of how audit is reported and the structure within ABUHB.	March 2023	Executives: Dr James Calvert/ Jenny Winslade/ Peter Carr / Assistant Directors
The recommendations in this report will be shared with the Assistant Directors for Quality and Patient Safety in Nursing and Therapies & Health Science, thus ensuring the audit guidance extends into all aspects of governance for ABUHB. There is work underway to develop a standardised annual plan for each Directorate to report on Quality based data, including clinical audit and will be used to inform a quality improvement plan and adoption of risk registers.	June 2023	Assistant Directors QPS – Leeanne Lewis/ Tracey Partridge-Wilson / Karen Hatch
The Clinical Audit team will be reviewing our implementation plan for clinical audit. The plan will include sign off for audit plans within AMaT to review risks and escalation. The plan will need to include an ongoing funding stream for AMaT. As part of the feedback, the internal auditor highlighted the lack of resource at ABUHB to lead and support the clinical audit plan and implementation of AMaT. As part of the implementation plan a consideration will be given to resources within the Clinical Audit Team. Currently the resource is a 0.8WTE Clinical Audit Lead who delivers both the National Clinical Audit and Local Audit Plans. This post has also taken on implementation and training of AMaT. This is an ambitious workload for full implementation of the Strategy.	June 2023	Assistant Director QPS (Leeanne Lewis) / Quality and Patient Safety Lead for National Clinical Audit / Dr Leo Pinto

Matter arising 2: Local clinical audit plan (Design)	Impact
There is no local clinical audit plan in place. Until recently, there has been little governance over what local clinical audits have been completed. We were unable to be provided with a list of local clinical audits completed for the past year as this list did not exist. Furthermore, there is no approach or oversight for identifying clinical risks and how these may be incorporated into a local clinical audit plan.	Potential risk of: • Audits not being completed, and necessary remedial actions not being undertaken, increasing risk to patient harm. • Lessons learnt from audits are not being distributed increasing risk to patient harm. • Clinical risks are not identified.

Recommendations	Priority
2.1 The Health Board should create a local clinical audit plan using a risk-based approach.	High
2.2 The clinical audit plan should be monitored at an appropriate forum, to ensure lessons are learnt across the Health Board and that the plan is being delivered effectively.	High
2.3 The local clinical audits should be recorded onto AMaT, as is currently being done with national clinical audits.	Medium

Management response	Target Date	Responsible Officer
2.1 As part of the Clinical Audit Strategy an implementation plan will be developed to ensure the necessary resources, governance and organisational structures are in place to support complete engagement in audits, reviews and national registries included in the annual Plan. The strategy includes the requirement for Divisions and Corporate leads to develop Clinical Audits plans aligned to quality and safety risk with a key set of benchmarks to support this.	March 2023	Assistant Director QPS (Leeanne Lewis) / CSEG / Divisional Triumvirate/ Executive Leads

	The plan will ensure ABUHB has clear lines of communication which ensures full Board engagement in the consideration of audit results and review of findings and, where required, the change process to ensure improvements in the quality and safety of services take place.		
2.2	The Divisional Triumvirates will be sighted on all relevant documents relating to Clinical Audit, as well as the Clinical Lead. Audit should be mandatory and non-performance will be challenged. AMaT will facilitate clinical audit and provide an oversight of the data. This will improve accountability for clinical audits, developing a clear action plan and allow tracking of actions, providing assurance to the Committee and Executive Board. Going forward there will be standardised approach to reporting audit findings. These will be reported under: • Areas where good practice has been identified • Areas of where practice requires improvement • Actions to be taken - using SMART objectives We will ensure learning from audit and review is shared across the organisation and communicated to staff and patients.	January 2023	Assistant Director QPS (Leeanne Lewis) / Quality and Patient Safety Lead for National Clinical Audit / Dr Leo Pinto / CSEG / Divisional Triumvirate
2.3	It is acknowledged that the current process in ABUHB for local audit has lacked structure and formal documentation. AMaT will be utilised for local audit and will enable the development of a formally recognised process for reviewing the organisations performance when reports are published. The AMaT report will include consideration of improvements (planned and delivered) and an escalation process to ensure the executive board is made aware when issues around participation, improvement and risk identification against recommendation are identified.	March 2023	Assistant Director QPS (Leeanne Lewis) / Quality and Patient Safety Lead for National Clinical Audit / Dr Leo Pinto
	The Clinical audit lead, CSEG and the Assistant Medical Directors will scope how to mandate the use of AMAT. We will agree on a formal process for registering a local audit (which sets out audit lead, reason for audit (e.g. complaint response etc etc), methodology (e.g. how will data be collected and analysed), standard being audited against, timeline, when report due and action to be taken from audit (including where result will be presented). This will be approved in advance – with prioritisation e.g. National audit takes precedence and local audit not addressing a risk issue as lowest priority. **All** audits will be registered.	June 2023	Assistant Director QPS (Leeanne Lewis) / Clinical audit lead / CSEG / Assistant Medical Directors

Matter arising 3: National clinical audits (Design)	Impact
The Quality and Patient Safety Lead for National Clinical Audit could not identify a deadline by which each national clinical audit had to be completed. This sometimes leads to difficulty obtaining participation from some divisions, particularly where staffing resources may be an issue. We could not therefore confirm whether each audit was completed in a timely manner as this information is not tracked. We were unable to confirm that national clinical audits inform the Health Board's future planning or that actions raised are monitored and tracked. Clinical audit is only mentioned fleetingly in the Health Board's Integrated Medium-Term Plan (IMTP).	Potential risk of: • Audits may be completed some time after they were included within the national clinical audit programme. • Data used may be significantly out of date and therefore may not be useful. • Planning does not take into account actions identified from clinical audits.

Recommendations	Priority
3.1 The Clinical Standards Effectiveness Group should monitor when an audit is added to the national clinical audit programme and how long it is scheduled to complete. Those responsible for completing audits that are facing significant delays should be asked to provide reasoning for this, and additional support should be provided where required.	Medium
3.2 Actions and findings from national and local clinical audits should be monitored at an appropriate forum and should be utilised to inform future planning within the Health Board.	Medium

Management response	Target Date	Responsible Officer
3.1 As each National Clinical Audit (NCA) is published it will be added to the web-based audit tracking system AMaT and assigned to a Clinical Lead. The Clinical Lead will act as a champion and point of contact for every National Clinical Audit and Outcome Review which the Health Board is participating in. Full participation is expected in ALL NCAs. The NCA programme for 2022/23 will be shared with Clinical audit leads to allow planning for attendance at CSEG.	March 2023	Assistant Director QPS (Leeanne Lewis) / Quality and Patient Safety Lead for National Clinical Audit / Dr Leo Pinto

	AMaT is seen as the solution to effectively recording audit results, tracking progress and challenges and developing an action plan within a specific timeframe. With the introduction of AMaT, there will be positive engagement for participation in audit. Audit should be mandatory and non-performance must be challenged. ABUHB is in the process of training staff to use AMaT, currently 90 users are registered. All National Clinical Audits are to be registered. The Clinical Audit Strategy states that all NCA's will be registered on AMaT with relevant documentation uploaded and allocated an audit lead. The Clinical Lead is the audit mentor for the specialty of the NCA. There are currently 35 audits registered in the Clinical Audit area on AMaT.	March 2023	Assistant Director QPS (Leeanne Lewis) / CSEG / Divisional Triumvirate / Clinical Leads
3.2	The use of AMaT will allow reports to be easily produced for Clinical Directors and Clinical Audit Leads. Key benefits include simple management of audits, easy management of reaudits, visibility of noncompliance and areas of focus for future improvement projects. AMaT will facilitate clinical audit and provide an oversight of the data. This will improve accountability for clinical audits, developing a clear action plan and allow tracking of actions, providing assurance to the Committee and Executive Board.	March 2023	Assistant Director QPS (Leeanne Lewis) / CSEG / Divisional Triumvirate / Clinical Leads
	Going forward there will be standardised approach to reporting audit findings. These will be reported under: • Areas where good practice has been identified • Areas of where practice requires improvement • Actions to be taken - using SMART objectives The Clinical Standards and Effectiveness Group (CSEG) oversees the governance relating to clinical audit and reports biannually to PQSOC the outcomes and improvements plans relating to national audit.		Assistant Director QPS (Leeanne Lewis) / Quality and Patient Safety Lead for National Clinical Audit / Dr Leo Pinto

Matter arising 4: AMaT user guide (Design)	Impact
The AMaT system is used to add the information from national clinical audits and going forward also local clinical audits. Those who are responsible for adding the local clinical audit information to the system may be unfamiliar or unsure how to best utilise the programme. There is an AMaT guidebook available, but this is not held on the Intranet.	Potential risk of: • The AMaT system not being used to its full potential

Recommendations	Priority
4.1 Add the AMaT guidebook to the Intranet.	Low

Management response	Target Date	Responsible Officer
4.1 This will be actioned, the AMaT guidebook will be added to the Clinical Audit intranet page for ABUHB.	December 2022	Quality and Patient Safety Lead for National Clinical Audit

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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Audit, Risk and Assurance Committee Update – **Aneurin Bevan University Health Board**

Date issued: December, 2022

Document reference: 2813A2022

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

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

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Contents

Audit, Risk and Assurance Committee Update

About this document

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

Accounts audit update

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

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of the 2021-22 Performance Report, Accountability Report and Financial Statements	Complete. The Auditor General certified the Performance Report, Accountability Report, and Financial Statements on 17 June 2022 and were laid before the Senedd the same day.
2021 Audit Plan	Completed; presented to the April Committee meeting.
Audit of Accounts Report	Completed and ISA 260 report presented to the June Committee meeting.
Charitable Funds: • 2021-22 Audit Plan • Audit of Charitable Funds financial statements	The audit of the Charitable Funds financial statements commenced 14 November 2022. We plan to present the 21-22 Audit Plan and the Audit of Accounts Report to the Charitable Funds Committee in January 2023.

3 We held a joint post project learning (PPL) session between the Finance Team and the audit team on 26 October to reflect on the 2021-22 audit, and to put in place agreed actions to further improve next year's closedown and audit experience. Following the PPL session, we issued a draft Audit of Accounts Addendum Report to management and once agreed, the Report will be presented to the Audit, Risk and Assurance Committee.

Performance audit update

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

- work completed (**Exhibit 2**);
- work that is currently underway (**Exhibit 3**); and
- planned work not yet started or revised (**Exhibit 4**).

Exhibit 2 – Work completed

Area of work	Considered by Audit. Risk and Assurance Committee
Quality Governance	Completed and findings presented to Patient Quality, Safety and Outcomes Committee in June 2022.

Exhibit 3 – work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit and Risk and Assurance Committee consideration
Structured Assessment 2022	The structured assessment work will assess the corporate arrangements in place at the Health Board in relation to: • Governance and leadership. • Financial management. • Strategic planning, and	Current Status: Report issued as draft Planned Date for Consideration: February 2023.

Topic and relevant Executive Lead	Focus of the work	Current status and Audit and Risk and Assurance Committee consideration
	• Managing the workforce, digital, resources, estates, and other physical assets.	
Review of arrangements for securing efficiencies Executive Lead: Rob Holcombe	This work will consider whether the Health Board's arrangements for securing efficiencies are robust, including the impact of new ways of working on planned efficiencies.	Current Status: Report issued as draft Planned Date for Consideration: February 2023
Orthopaedic Follow up review Executive Lead: Leanne Watkins	This review is examining the progress made in response to our 2015 recommendations. The report will take stock of the significant elective backlog challenges and consider the impact of the pandemic and orthopaedic service recovery. Therefore, reporting was moved to 2022.	Current Status: We are preparing an all-Wales summary report, and considering preparation of a discrete Annex for each Health Board. Expecting to issue all Wales summary draft by end of January.
Unscheduled care arrangements Executive Lead: Leanne Watkins / Chris O'Conner	This work has been carried forward from the 2020 Audit Plan and will initially look to provide a high-level whole system overview of the unscheduled care. The overview will be informed by the development of an interactive database covering all aspects of the unscheduled care pathway. Further work will then be undertaken on specific elements of unscheduled care	Unscheduled Care Blog issued April 2022 alongside data tool. Fieldwork underway Planned date for consideration: TBC

Topic and relevant Executive Lead	Focus of the work	Current status and Audit and Risk and Assurance Committee consideration
	pathway, with a likely focus on activities to signpost patients to the most to appropriate care setting, and to manage patient flow through the system.	

Exhibit 4 – Planned work not yet started or revised

Topic and relevant Executive Lead	Focus of the work	Current status and Audit, Risk and Assurance Committee consideration
Follow-Up of Primary Care Services	Follow-up of recommendations made in our Primary Care services review	Date for consideration to be confirmed.
All-Wales thematic on workforce planning arrangements	This work will examine the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs. The work will be tailored to align to the responsibilities of individual NHS bodies in respect of workforce planning.	We issued the project brief in November. The fieldwork is planned in the next calendar year.

Good Practice events and products

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

6 There has been one Good Practice Exchange (GPX) event since we last reported to the Committee on 6th October. Making Equality Impact Assessments more than a tick box exercise | Audit Wales. Details of future events are available on the GPX Website.

NHS-related national studies and related products

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

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

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

Title	Publication date
Equality Impact Assessment: More than a tick box exercise? The key messages are summarised in **Appendix 1**	September 2022
Learning from Cyber Attacks The key messages will be summarised in a separate paper to be considered in the Audit, Risk and Assurance Committee private meeting in February 2023	October 2022

Appendix 1 – Key messages from recent national publications

Equality Impact Assessments: More than a tick box exercise? (September 2022)

9 Our work looked at the overall approach to undertaking Equality Impact Assessments in public bodies in Wales. We concentrated on the 44 public bodies originally subject to the Well-being of Future Generations (Wales) Act 2015.

10 We focussed primarily on understanding public bodies' approaches with a view to finding good or interesting practice and identifying any common areas for improvement. We did not evaluate individual public bodies' approaches in detail.

11 Our findings highlight examples of good practice in aspects of the Equality Impact Assessment process across the public bodies we looked at. However, there are areas for improvement around the following themes:

- Greater clarity over which type of policies must be impact assessed.
- Greater clarity about the arrangements for assessing the impact of collaborative policies and practices.
- Greater clarity about expectations to consider the Public Sector Equality Duty as part of an integrated impact assessment.
- Better monitoring of the actual impacts of policies and practices on people.
- A shift in the mindsets and cultures to move Equality Impact Assessments away from being seen as an add-on 'tick box' exercise.

12 Our report makes several recommendations for Welsh Government to address and one to public bodies requiring them to review their approach to Equality Impact Assessments considering the findings within the report and detailed guidance available on the Equality and Human Rights Commission and Practice Hub.

Audit Wales
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Audit of Accounts Report Addendum – Aneurin Bevan University Health Board

Audit year: 2021-22

Date issued: November 2022

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Audit of Accounts Report Addendum

Introduction

1 This report is an addendum to our Audit of Accounts Report that we presented to the Audit Risk and Finance Committee on 13 June 2022, and to the Board on 14 June 2022. The report sets out the recommendations arising from our audit of the 2021-22 accounts and progress against prior year's audit recommendations.

2 We should like to take this opportunity to once again thank all your staff who helped us throughout the audit.

Recommendations from this year's audit

3 We summarise in **Exhibit 1** our recommendations arising from this year's audit.

Exhibit 1: Matters Arising, A – E (2021-22)

Matter arising A (2021-22) – Asset verification reviews should be undertaken annually	
Findings	Due to COVID, the Health Board decided not to undertake its annual asset impairment review and the process for verifying asset existence as at 31 March. As part of our review of asset lives, we sample tested assets recorded as having a Net Book Value (NBV) of 'nil'. Our review of these assets found that all of our sample tested were no longer in use and therefore the Gross Book Value (GBV) of these assets was overstated. Further testing of an extended sample, identified further errors, resulting in a total error rate of 33% for the total population sample tested. The total GBV for those assets amounts to £49.9 million, and therefore the potential overstatement of the GBV is £16.5 million. Further work was undertaken by the Finance Team to provide assurance that the GBV was not materially miss-stated. The Finance Team received confirmation for assets totalling a GBV of £24.4 million, of which £5.1 million was confirmed as no longer in use and the financial statements were amended accordingly. In addition, responses from departments highlighted uncertainty over asset existence to a further value of £1.5 million, leading to a potential error of 25% (£6.6 million out of £25.9 million responses). Extrapolation of this error rate to the remaining £24 million assets, indicates a potential mis-statement of £6 million, which is below our materiality for the financial statements. The asset tagging system which is currently being rolled out should provide assurance over the existence of assets as at 31 March.
Priority	High
Recommendation	Until all assets are tagged, the Health Board should undertake an annual asset verification review, to ensure the verification of asset existence and values are correct/not materially mis-stated as at 31 March.
Benefits of implementing the recommendation	This will ensure that the financial statements are not materially mis-stated.

Matter arising A (2021-22) – Asset verification reviews should be undertaken annually	
Accepted in full by management	Yes
Management response	A system is in place to ensure this will take place this year and an update is being reported to the Audit Committee on 1 December 2022.
Implementation date	31 March 2023

Matter arising B (2021-22) – A quality assurance review should be undertaken on the draft Remuneration Report prior to audit	
Findings	Our work identified a number of amendments to the Remuneration Report which included: • inclusion of annualised salaries for those individuals who were only in post for part of the year; and • inclusion of correct post titles. The note was both further complicated by the number of staff changes at Senior Management level and Board members.
Priority	High
Recommendation	The draft Remuneration Report should be subject to a quality assurance review to ensure compliance with the relevant guidance from the Welsh Government. This is particularly important for 2022-23 due to the high number of changes at senior management level that will have taken place during the financial year.
Benefits of implementing the recommendation	This will ensure that the Remuneration Report will comply with relevant guidance
Accepted in full by management	Yes

Matter arising B (2021-22) – A quality assurance review should be undertaken on the draft Remuneration Report prior to audit	
Management response	Improvements put in place by the Director of Corporate Governance's team and Finance should ensure these issues don't take place this year.
Implementation date	31 March 2023

Matter arising C (2021-22) – IT Disaster Recovery (DR) plans should be regularly tested	
Findings	The health boards IT DR plans were being updated in 2022 and we reported this in our 2020 -21 audit work. It is good practice to regularly test DR plans, at least annually, and then update these to provide assurance that IT systems can be recovered from backups and plans work as intended when needed. IT DR plans should also include a cyber-attack as a planned scenario if a separate cyber security incident response plan has not already been documented.
Priority	High
Recommendation	Test the IT DR plans to ensure these works as intended and document a test schedule and outcomes to record any improvement areas identified.
Benefits of implementing the recommendation	This will ensure that the DR plans work as intended should systems recovery be required.
Accepted in full by management	Yes
Management response	The updated IT DR plan has been tested in June and October 2022 and any improvements identified have been implemented. Regular test schedules will be established with the services following the data centre move migration project.

Matter arising C (2021-22) – IT Disaster Recovery (DR) plans should be regularly tested	
Implementation date	April 2023

Matter arising D (2021-22) – Internal network vulnerability assessments should be scheduled on a regular basis	
Findings	Internal network vulnerability assessments (NVA's) or scans have commenced in 2022 but at the time of our fieldwork, were infrequent and not run on a regular and scheduled basis. NVA's are used to identify and analyse potential security vulnerabilities. In addition, the outputs from Nessus, the scanning tool used, are not actively monitored. Monitoring of the reports is by exception based on the criticality of the issues identified. NVA's should include a range of IT infrastructure and network software and devices including servers, new IT systems, operating systems and desktop/laptop devices.
Priority	High
Recommendation	Complete regular, for example, weekly or monthly, and scheduled internal scheduled network vulnerability assessments and actively monitor findings identified.
Benefits of implementing the recommendation	This will ensure that any issues are assessed and actions that need to be addressed, are done so as a priority.
Accepted in full by management	Yes
Management response	The internal network vulnerability assessments have been re-introduced on our IT estate. These will be actively monitored, and findings reported to the appropriate IT department teams for remediation.
Implementation date	December 2022

Follow-up of recommendations from prior year's audit

4 We summarise in **Exhibit 2 progress made against** our recommendations arising from previous year's audit. Of the five recommendations, one has been completed and four are ongoing.

Exhibit 2: Matters Arising, A – E (2020-21)

Matter arising A (2020-21) – Recording of annual leave for Medical/Dental staff requires strengthening	
Priority	High
Recommendation	The Health Board should review the arrangements in place to ensure that annual leave for all staff is accurately recorded and held centrally
Benefits of implementing the recommendation	To provide the Health Board greater assurance over the accuracy of their data and provide a clear audit trail for the estimate of the annual leave accrual.
Accepted in full by management	Yes
Management response	The introduction of Medical E-Systems will ensure that all leave is recorded. The Health Board have agreed to procure a suite of Medical E-Systems with roll out in April 2022. However, departments have started recording leave in Electronic Staff Record (ESR). Communications will be sent to Medical Leaders in December 2021 to ensure that leave is recorded onto ESR pending the introduction of full Medical E-Systems.
Implementation date	April 2022
Progress as at October 2022	**Ongoing** As reported to the October Audit, Risk and Assurance Committee, *'Given the current pressures on staff it was felt that an interim system change of 12 months would be beneficial. Roll out of E-Systems will commence February 2023.'* It should be noted that for the financial year 2022-23 and beyond, all NHS employees will no longer be

Matter arising A (2020-21) – Recording of annual leave for Medical/Dental staff requires strengthening	
	permitted to carry forward untaken annual leave at the year end. The ability to do this previously was for a two-year period due to the impact of COVID-19. Therefore, an estimation for an annual leave accrual as at 31 March will no longer be required. That said, the recommendation still remains valid.
Management response	The Medical e-systems Programme Manager has identified revised dates for the procurement process.

Matter arising B (2020-21) – Audit evidence to complete payroll testing needs to be timelier	
Priority	High
Recommendation	The Health Board should hold workshops with Audit Wales to discuss what information is required to provide assurance for the audit, and what are the best ways of obtaining this.
Benefits of implementing the recommendation	This will help ensure that the audit is completed as efficiently as possible and reduce audit queries.
Accepted in full by management	Yes
Management response	A workshop will be arranged with Audit Wales in January 2022 to ascertain the information required in order to substantively test payroll transactions. Relevant Health Board employees will be invited to attend this workshop to ensure that going forward information is provided in the format required and on a timely basis.
Implementation date	January 2022
Progress as at October 2022	Completed

Matter arising C (2020-21) – IT Controls require strengthening in a number of areas	
Priority	Medium
Recommendation	The Health Board should consider strengthening their IT Controls as follows: i. All of the Windows server 2008 operating system should be replaced with either or Windows 2012 or higher where possible (this is almost completed with only twenty three servers left). ii. W7 and W8.1 desktop devices should be replaced as these are now de-supported. iii. Ensure that the change management procedure is finalised. iv. The IT Data Recovery Plan and Backup Policy should be updated and clearly defined. v. With regards to the Wellsky system: a. leavers and accesses changes should be formally recorded; and b. the Health Board should develop a suite of audit and security reports to run and monitor to ensure user access is appropriate.
Benefits of implementing the recommendation	Greater assurance over the Health Board's IT security
Accepted in full by management	Yes
Management response	i. We have an active programme of work to either upgrade or decommission these Windows 2008 servers by the end of Quarter 4 2021-22. ii. There is an active programme to replace W7 and W8.1 desktop devices or upgrade them to a supported version of Windows 10. Capital to upgrade these systems has been identified and a funding request made to discretionary capital. Until funding is secured it is not possible to give accurate timescales. iii. A change management process has been documented and finalised. Key Performance Indicators (KPIs) are agreed and measured to assess effectiveness. These KPIs will be added to the monthly/quarterly reporting to

Matter arising C (2020-21) – IT Controls require strengthening in a number of areas	
	the IT Management Team and Digital Delivery Oversight Board. iv. The IT Data Recovery Plan and Backup Policy is still in the process of being reviewed and updated. A draft version has been shared within the team and the finalised version will be published December 2021 for Digital Delivery Oversight Board approval. v. With regards to the WellSky system: a. the Health Board plan to extend current Excel record system of leavers and access change to include designated form and Share-point records. b. the Health Board plan to engage with Digital Health Care Wales/WellSky to enquire about potential of obtaining information /reports on failed user access attempts so this can be monitored.
Implementation date	i. 31 March 2022 ii. 31 December 2022 iii. 31 December 2021 iv. 31 March 2022 v. a. 31 December 2021 b. 30 November 2021
Progress as at October 2022	i. Ongoing ii. Ongoing iii. Confirmed this was completed iv. Completed v. Completed
Management response	i.Currently there are 2 remaining servers left on WS 2008. These rely on upgrades to the software applications to enable the move to a supported Windows Server version. The IT department will continue to liaise with the services to remove the last 2 remaining. ii. Currently 3 devices are remaining. The IT department will continue to liaise with the services to remove these last remaining devices

Matter arising D (2020-21) – A quality assurance review should be undertaken on the draft Annual Report and Annual Governance Statement prior to audit	
Priority	Medium
Recommendation	The draft Annual Report and Annual Governance Statement should be subject to a Quality Assurance review to ensure compliance with the Manual for Accounts, with evidence of this review submitted for audit as part of the supporting working papers.
Benefits of implementing the recommendation	This will ensure that the Annual Report and Annual Governance Statement comply with relevant guidance.
Accepted in full by management	Yes
Management response	A checklist will be prepared to identify each area within the Manual for Accounts and link to the relevant part of the Annual Report and Annual Governance Statement. This checklist will be submitted to Audit Wales with the draft documents to facilitate review.
Implementation date	May 2022
Progress as at October 2022	**Ongoing** Whilst our audit of the Annual Report and Annual Governance Statement noted improvements in this area, there is further work that can be done to ensure that the compliance with the requirements of the Manual for Accounts is complied with.
Management response	Further work in this area is ongoing and a much improved position is anticipated.

Matter arising E (2020-21) – The new asset tagging system should be implemented in readiness for the audit of the 2021-22 financial statements	
Priority	Low
Recommendation	The new asset tagging system should be implemented as soon as possible, and in readiness for the audit of the 2021-22 financial statements.
Benefits of implementing the recommendation	This will ensure accurate tracking and management of the Health Board's physical assets and provide a clear audit trail to give assurance over the existence of the Health Board's assets at the year end.
Accepted in full by management	Yes
Management response	The interface between the Fixed Asset Register (Asset 4000) and the new RFID system is complete. The team are working through final issues identified on the user testing of the interface between the EBME equipment register and the RFID system during November 2021, with a view to going live with the system by the end of the month. The user training sessions have taken place. The tagging of new and existing equipment assets has commenced with around 1400 assets tagged to date. The programme of tagging of existing assets will run into the 2022/23 financial year due to the volume of assets and current capacity of staff. However, the finance team are progressing a fixed term appointment to support the delivery of this work over the next year.
Implementation date	2022-23
Progress as at October 2022	**Ongoing** Asset tagging continues on a site-by-site basis. An additional post, which will be filled in December has been created, to help expediate the completion of the asset tagging process. However due to the volume of assets to be tagged, not all assets will be tagged before 31 March 2023. The Finance Team will look to arrange a manual asset verification exercise for those assets not tagged by this date in readiness for the completion of the draft financial statements 2022-23.
Management response	In progress (see first recommendation)

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The National Fraud Initiative in Wales 2020-21

Report of the Auditor General for Wales

This is an interactive pdf

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Since we last reported on the National Fraud Initiative (NFI) in Wales in October 2020, outcomes valued at £6.5 million have been recorded. The cumulative total of outcomes from the NFI in Wales since NFI started in 1996 are now £49.4 million. Across the UK, the cumulative total of NFI outcomes is now £2.37 billion.

NFI outcomes in Wales decreased by £1.5 million to £6.5 million in the 2020-21 exercise. This was primarily because fewer ineligible claims for Council Tax Single Persons Discount and Housing Benefit claims were detected, reflecting the fact that some local authorities started review of NFI matches later than normal due to Covid-19 pressures.

Data sharing enables matches to be made between bodies and across national borders. Data submitted by Welsh bodies for the 2020-21 NFI exercise helped organisations in other parts of the UK to identify 153 cases of fraud and error with outcomes of £183,045.

While the majority of Welsh NFI participants display a strong commitment to counter fraud, 13 of the 22 Welsh local authorities identified 95% of the fraud and error outcomes achieved by the sector. This suggests that some local authorities have either failed to recognise the importance of the exercise or are unwilling to allocate adequate, skilled counter-fraud resources to investigate the NFI matches.

One Welsh local authority, Cardiff Council, agreed to participate in an exercise designed to identify fraud and error in applications for COVID-19 business support grants by verifying applicant bank details and trading status. These checks helped to identify outcomes of just under £0.6 million relating to 41 fraudulent or erroneous applications.

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Recommendations

All participants in the NFI exercise should ensure that they maximise the benefits of their participation. They should consider whether it is possible to work more efficiently on the NFI matches by reviewing the guidance section within the NFI secure web application.

Where local auditors recommend improving the timeliness and rigour with which NFI matches are reviewed, NFI participants should take appropriate action.

Audit committees, or equivalent, and officers leading the NFI should review the NFI self-appraisal checklist. This will ensure they are fully informed of their organisation's planning and progress in the 2022-23 NFI exercise.

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NFI outcomes

NFI is a counter-fraud exercise across the UK public sector which aims to prevent and detect fraud. NFI uses data sharing and matching to help confirm that services are provided to the correct people.

An NFI outcome describes the overall amounts for fraud, overpayments and error that are detected by the NFI exercise and an estimate of future losses that it prevents.

The NFI recorded outcomes of £6.5 million in 2020-21.

NFI outcomes cumulatively in the UK since 1996-97

£2.37 billion

NFI outcomes cumulatively in Wales since 1996-97

£49.4 million

NFI outcomes across the UK from the 2020-21 exercise

£443 million

NFI outcomes in Wales from the 2020-21 exercise

£6.5 million

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Trends in outcomes

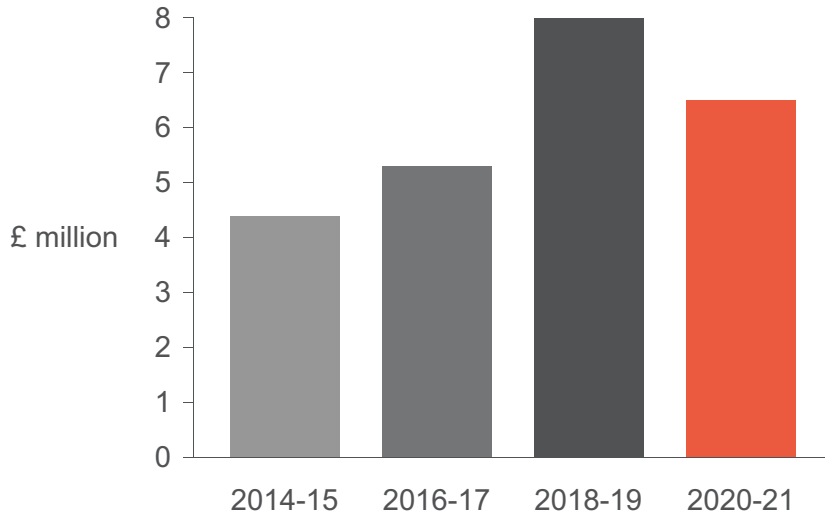
Outcomes in Wales have decreased by £1.5 million to £6.5 million in the 2020-21 exercise. Reasons for the decrease in outcomes include:

- the number of fraudulent or erroneous claims for Council Tax Single Persons Discount detected fell from 3,939 in the 2018-19 exercise to 1,987 in the 2020-21 exercise, resulting in outcomes in this area reducing by £2 million; and
- the number of fraudulent or erroneous claims for Housing Benefit detected fell from 179 in the 2018-19 exercise to 82 cases in the 2020-21 exercise, resulting in outcomes in this area reducing by £0.6 million.

The above fall in outcomes was offset in part by:

- an increase in the number of fraudulent or erroneous applications for social housing detected from 74 in the 2018-19 exercise to 237 in the 2020-21 exercise, resulting in increased outcomes of £0.6 million; and
- the detection of 43 fraudulent or erroneous claims for COVID-19 business support grants resulting in cumulative outcomes of £0.6 million.

Outcomes of £6.5 million were identified in the 2020-21 exercise



While overall outcomes have fallen, this is in part because many NFI participants started review of NFI matches later than normal due to work pressures arising from the COVID-19 pandemic.

The only UK nation which saw an increase in 2020-21 NFI outcomes was England. This increase was due to a significant increase in pension outcomes from matching UK-wide pension scheme data.

Late savings arising from NFI 2020-21 will be reported as part of the NFI 2022-23 exercise.

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How the latest outcomes compare to the last exercise

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Seven areas generated almost 98% of outcomes

The areas which generated the most outcomes from the current exercise are as follows:

Category	£	Cases
Council tax discounts	£2.6m	1,987
Blue badges	£1.4m	2,717
Housing waiting lists	£0.8m	237
Housing benefit	£0.6m	84
COVID-19 business support grants	£0.6m	43
Council tax reduction scheme	£0.2m	214
Creditor payments	£0.1m	9

Once overpayments have been identified, public bodies can take appropriate action to recover the money. As at 31 March 2022, 81% of overpayments had been recovered or were in the process of being recovered.

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Council tax discounts

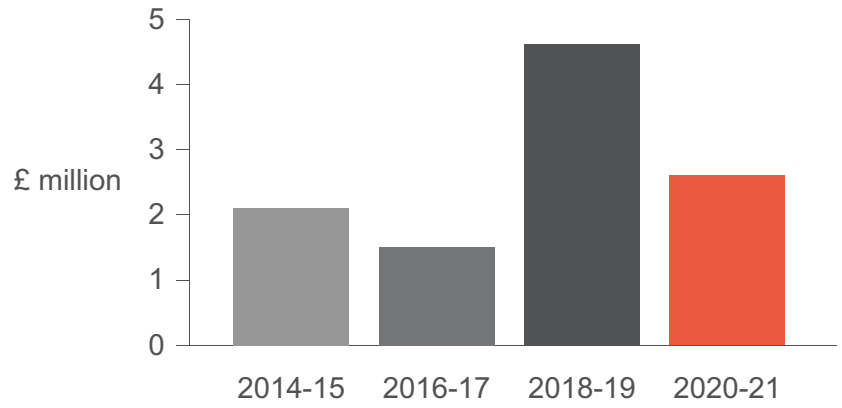
People living on their own, or with no countable adults in the same household, are eligible for a 25% single person discount (SPD) on their annual council tax bill.

Council tax SPD data is matched to electoral register data to help find where people are receiving the discount, but are not the only countable adult at their residence.

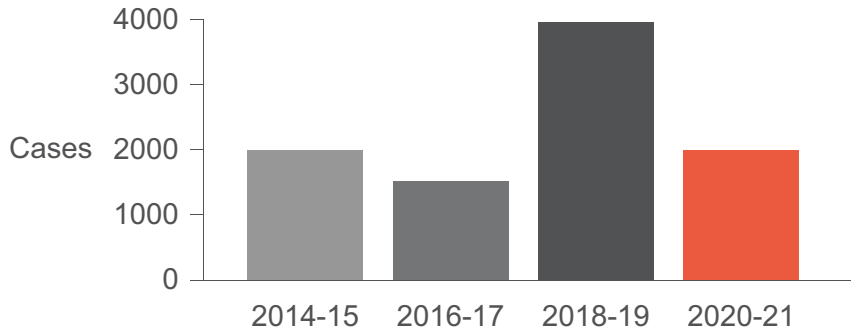
The 2020-21 NFI exercise found that the total council tax discount incorrectly awarded across Welsh local authorities totalled £2.6 million. This is an average outcome of £1,305 for each case (£1,003 per case in the 2018-19 NFI). Review of the NFI matches led to the cancellation of 1,987 SPD claims.

While the number of fraudulent or erroneous SPD claims detected fell from 3,939 to 1,987 in the current exercise, this is partly due to investigation of the matches being delayed due to the COVID-19 pandemic. Many claims have been cancelled since the cut-off date for reporting the NFI 2020-21 exercise and these 'late results' will be reported within NFI 2022-23.

Outcomes of **£2.6 million** in 2020-21



1,987 cases in 2020-21



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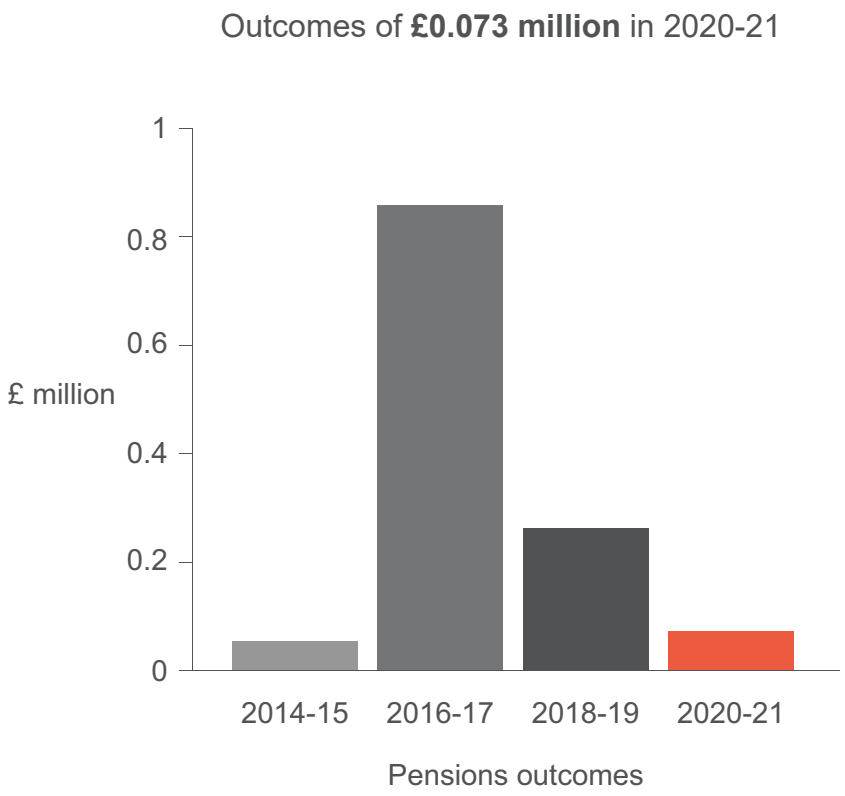
Pensions

The NFI provides local authorities that administer pensions with an efficient and effective way of checking that they are only paying people who are alive.

The exercise found nine instances where pensions had remained in payment after pensioners had died compared to ten cases in NFI 2018-19.

In total, pensions outcomes for the 2020-21 NFI exercise are £0.073 million.

This is a reduction of £0.26 million from the 2018-19 NFI exercise, and reflects the continuing impact of the 'tell us once' reporting process which is ensuring that local authorities become aware of the decease of pensioners earlier. While the number of cases detected by NFI has remained almost unchanged from NFI 2018-19, the average value of each case has fallen from £26,396 to £8,160, because the period of time pensions remained in payment after pensioners' death was shorter.



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Housing benefit

The NFI provides local authorities and the Department for Work and Pensions (DWP) with the opportunity to identify a wide range of benefit frauds and errors.

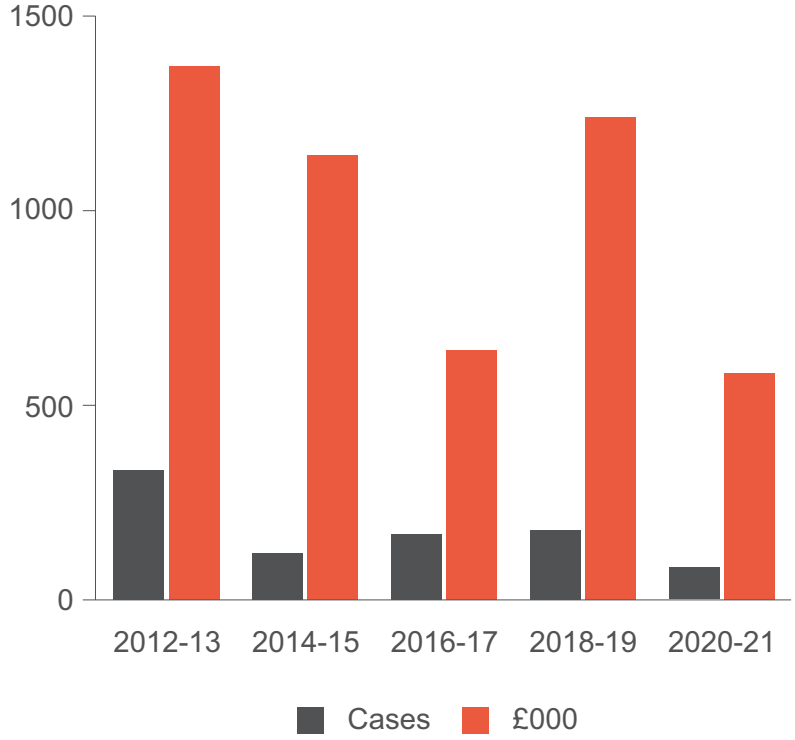
Housing benefit data is matched to student loans, payroll, pensions, housing benefit, housing tenants, licences, deceased person and Amberhill* data to help identify ineligible claims.

The value and number of housing benefit cases recorded with overpayments has reduced from £1.2 million (179 cases) in the 2018-19 exercise to £0.6 million (82 cases) in the 2020-21 exercise.

The fall in housing benefit cases outcomes is mainly due to matches between housing benefit and payroll and pension payments not being included in the 2020-21 exercise. These matches historically identified significant outcomes. These matches were not included as similar data matching is undertaking by the DWP's Verify Earnings and Pensions (VEP) Alerts service which identifies discrepancies between payroll and pension details held by HM Revenue & Customs and council benefits services. Alerts from VEP are sent to local authorities to investigate discrepancies.

*Amberhill is a system used by the Metropolitan Police to authenticate documents presented for identity.

Outcomes of **£0.6 million** in 2020-21



The majority of fraudulent and erroneous claims for housing benefit detected by local authorities in the 2020-21 exercise related to students who were in receipt of housing benefit when not entitled.

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Case Study: Housing benefit

Carmarthenshire County Council

The Council continues to recognise the value of NFI in protecting the public purse against the threat of fraud risks and considers NFI as being invaluable in the detection and prevention of fraud. The NFI 2020-21 exercise identified 33 housing benefit to student loan matches and of these 13 were high risk matches. Historically the Council has achieved significant results from this specific report and, as in previous exercises, extended the checking process to all matches. Review of the report identified fraud in 30% of the matches, where it was established that benefit customers had failed to declare they were in receipt of student finance/loans. These ten investigations identified overpayments of benefits in excess of £33,000. The Council has recovered the overpayments or remains in the process of full recovery.

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Blue badges

The blue badge parking scheme allows people with mobility problems to park for free at on-street parking meters, in pay and display bays, in designated blue badge spaces, and on single or double yellow lines in certain circumstances.

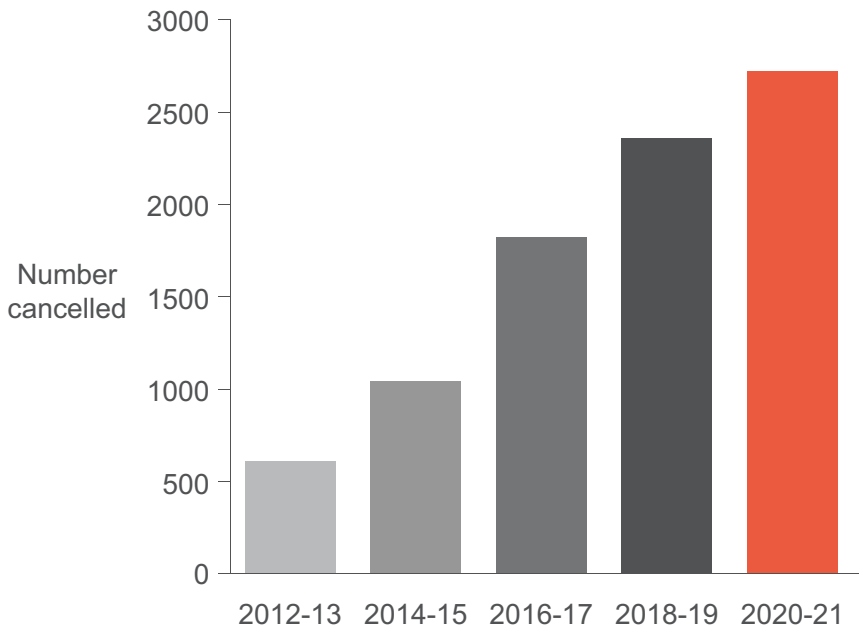
Blue badge data is matched to deceased persons and Amberhill data.

Badges are sometimes used or renewed improperly by people after the badge holder has died. It is an offence for an unauthorised person to use a blue badge.

NFI 2020-21 resulted in the cancellation of 2,717 blue badges in Wales. The number of badges cancelled has increased in each NFI exercise since NFI 2012-13. The estimated value of these cases is £1.4 million based on a calculation of the annual estimated cost of lost parking revenue and the likelihood of these blue badges being misused.

The increase in outcomes is due to a growing recognition of the need to prevent misuse of blue badges. Not only does such misuse reduce parking revenues, it also limits the parking facilities available to genuine blue badge holders.

2,717 outcomes in NFI 2020-21



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Housing waiting lists

NFI uses housing waiting list data to identify possible cases of waiting list fraud. This happens when an individual has registered on the waiting list but there are possible undisclosed changes in circumstances or false information has been provided. This was a new data set for the 2016-17 NFI exercise.

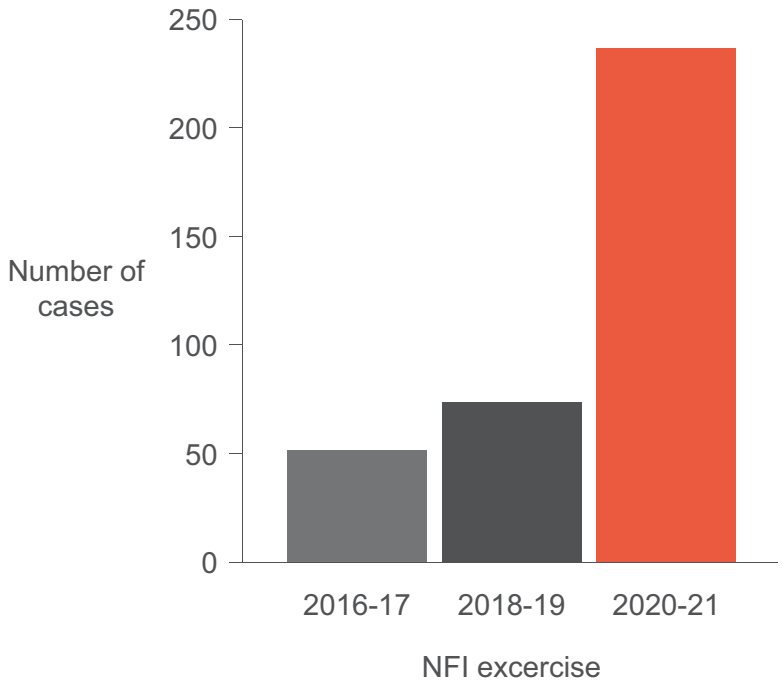
Housing waiting list data is matched to waiting list, housing benefit, housing tenants, deceased persons and Amberhill data.

Local authorities identified 237 cases where applicants were removed from waiting lists compared to 74 cases in 2018-19.

The estimated value of these cases is just under £0.8 million based on a calculation of the annual estimated cost of housing a family in temporary accommodation and the likelihood a waiting list applicant would be provided with a property.

The increase in the number of applications cancelled is due to increased efforts by local authorities to review the NFI matches thereby helping ensure that social housing is only provided to eligible persons.

Number of applicants removed from housing waiting lists



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Creditor payments

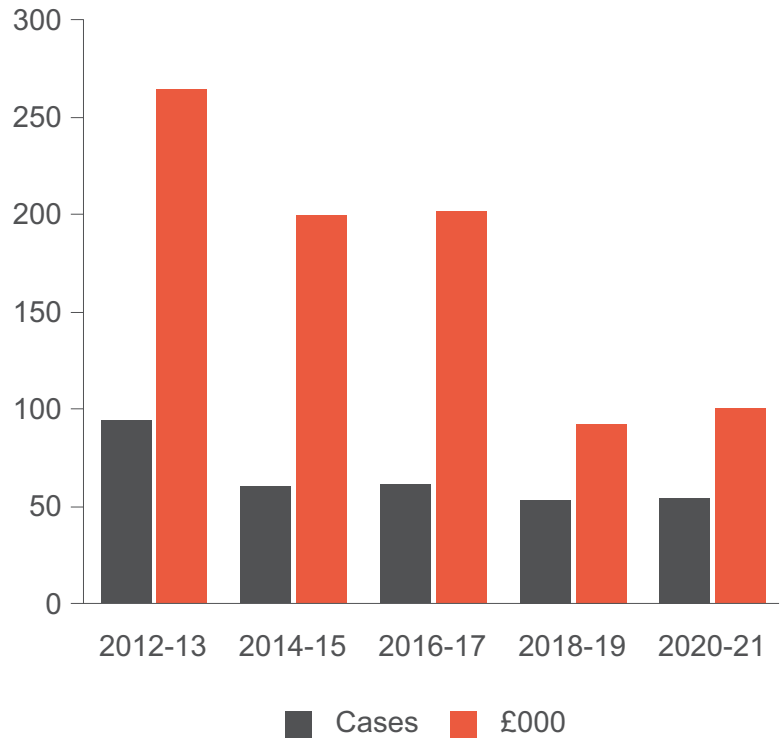
The NFI provides an efficient way to check for duplicate payments and that payments are only made to appropriate creditors.

Creditor payment data is also matched to payroll and Companies House data to help identify undisclosed staff interests in suppliers.

NFI 2020-21 resulted in 54 creditor payment outcomes totalling just over £0.1 million compared to 53 outcomes totalling just under £0.1 million in NFI 2018-19. Recovery action has already taken place or is in process for all of these overpayments.

Creditor payment outcomes have reduced over NFI exercises as participating bodies have improved their internal control systems.

Outcomes of **£0.1 million** in 2020-21



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Council tax reduction

Council tax reduction helps those on low incomes to pay their council tax bills.

The NFI provides local authorities with the opportunity to identify a range of council tax reduction frauds and errors.

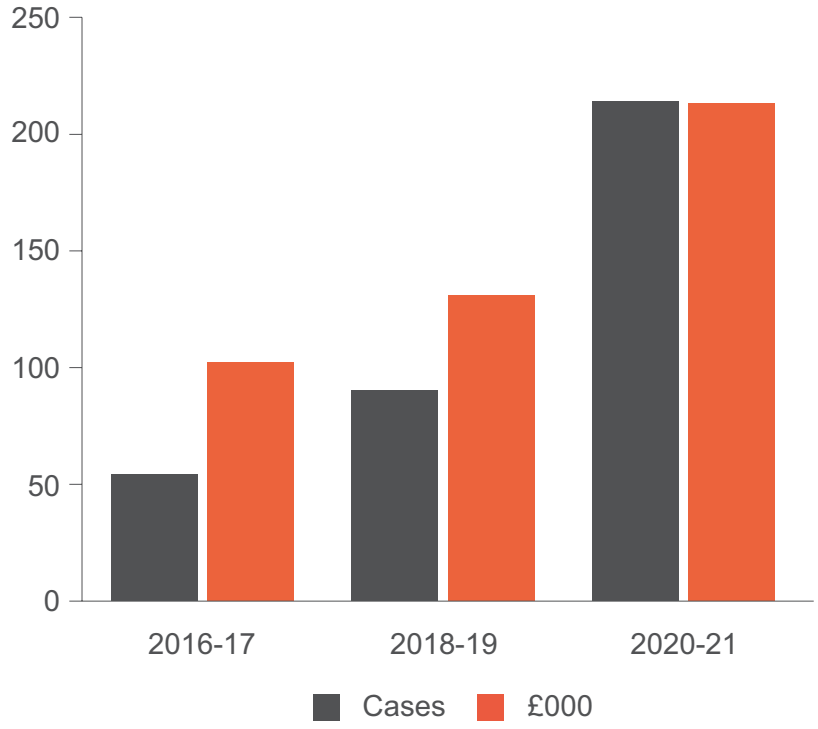
Council tax reduction data is matched to council tax reduction, payroll, pensions payroll, housing benefits, housing tenants, licences, deceased persons and Amberhill data.

The 2016-17 NFI was the first time council tax reduction data sets were included within the NFI.

Outcomes of £0.21 million were identified in the 2020-21 NFI and claims for council tax reduction were amended or cancelled in 214 cases.

The average value of each case was £1,015 compared to £1,457 in NFI 2018-19 suggesting that fraud and error is being identified earlier.

Outcomes of **£0.21 million** in 2020-21



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Case study: Vale of Glamorgan Council

The Council has a proactive and comprehensive approach to reviewing all NFI matches. All council tax reduction matches are reviewed by the Investigation Officer against the Council's internal systems to try and establish the current household status of claimants. One such match appeared to show the claimant had not declared an occupational pension that had been in payment since 2018. The Investigation Officer advised the Benefits Team that further investigation was required. The Benefits Team liaised with the Revenues Team and found there was another person residing at the address who was also in receipt of an undeclared occupational pension and who had received a substantial lump sum pension payment in 2018. Despite numerous attempts to verify the current situation with the claimant, the claimant failed to respond. The Council has cancelled the claim and the claimant has agreed to repay an overclaim of £4,775 in monthly instalments.

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Use of HMRC Data in NFI

In NFI 2020-21, for the first time, Welsh NFI matches were enriched by HMRC data provided under the provisions of the Digital Economy Act 2017. The HMRC data is proving highly effective in helping to identify applicants who have claimed means-tested benefits and discounts but have not declared income that should have been declared on their applications.

Case Study: Denbighshire County Council

The Council proactively reviewed matches between Council Tax Reduction Scheme (CTRS) and HMRC's household composition. One match suggested there was an undeclared non-dependant in the household from 2017, so benefit payments were suspended. The Benefits Team had previously been notified that the person had left the household in March 2017. On investigation, the customer confirmed the failure to declare the non-dependant since May 2017. The NFI match showed the earnings of the non-dependant to be around the threshold at which the highest deduction to the claimant's benefits would apply, so in the absence of further evidence of the non-dependent's income, the is highest deduction was applied. This resulted in an overclaim totalling £20,782. The Council is in the process of recovering the overclaim.

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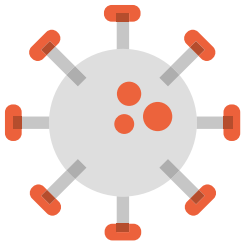
COVID-19 business support grants



In response to the COVID-19 pandemic, the Welsh Government put in place a package of measures to support businesses through the crisis. One of these measures included providing grant funding through Welsh local authorities to some retail, hospitality and leisure businesses and to businesses classified as small businesses for business rate purposes. NFI matched these grants to ensure that businesses were not inappropriately claiming multiple grants and that grants were not being awarded to known fraudsters. These checks only identified two cases of fraud and error amounting to £20,000, providing assurance that these practices were not common.

NFI also made optional tools available to local authorities to confirm that grant applicants were actively trading before the COVID-19 pandemic, and that bank account details provided by applicants related to legitimate business accounts. One Welsh local authority, Cardiff Council, used these tools in conjunction with other internal controls to identify 41 cases of fraud and error with a value of £575,000.

Case Study: Cardiff Council

Following the use of various upfront application and payment controls, the Council used a multi-layered approach to post payment verification and assurance processes for COVID-19 business support grants. NFI provided a useful source of intelligence as part of these post payment checks. The Corporate Fraud Investigation Team and colleagues in Business Rates used a range of investigative techniques and identified £575,000 of payments for recovery. For example, one NFI match indicated that a company had ceased trading, online enquiries suggested the business had closed and a Companies House check showed the company had dissolved prior to the grant eligibility date. The company had not notified the Council that they had ceased trading and were not eligible for the grant. The Council has recovered, or is is seeking to recover the overclaims wherever there is a realistic chance of doing so.

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Payments to residential care homes

In previous NFI exercises, NFI has matched residential care home data to deceased persons to identify cases where a care home resident has died, but the local authority has not been notified and so has continued to make payments to the care home.

In NFI 2018-19, 11 cases of overpayments were identified where Welsh local authorities were continuing to pay care homes for residents who had died. The average value of these cases was £14,545.

Due to the unintended consequence of a change to legislation affecting Wales, Scotland and England, it was not possible to undertake matching in this area as part of NFI 2020-21. The Auditor General is working with the Cabinet Office and Audit Scotland to find a legislative solution that will allow this matching to be undertaken in future NFI exercises.

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Matches benefiting other public bodies

One key benefit of a UK-wide data matching exercise is that it enables matches to be made between bodies and across national borders. Data provided by Welsh participants for the 2020-21 NFI exercise helped other public bodies outside Wales identify outcomes worth just over £183,000.

Sector of source data	£	Number of outcomes
Local authorities	162,776	135
NHS	15,811	17
Fire	4,458	1
Total	**183,045**	**153**

Most of these outcomes relate to housing benefits, housing waiting lists, and council tax reductions. For example, payroll data from a health board may allow a local authority to identify a housing benefit overpayment.

For those public bodies taking part in the NFI which may not always identify significant outcomes from their own matches, it is important to appreciate that providing their data can help other bodies and sectors identify frauds and overpayments.

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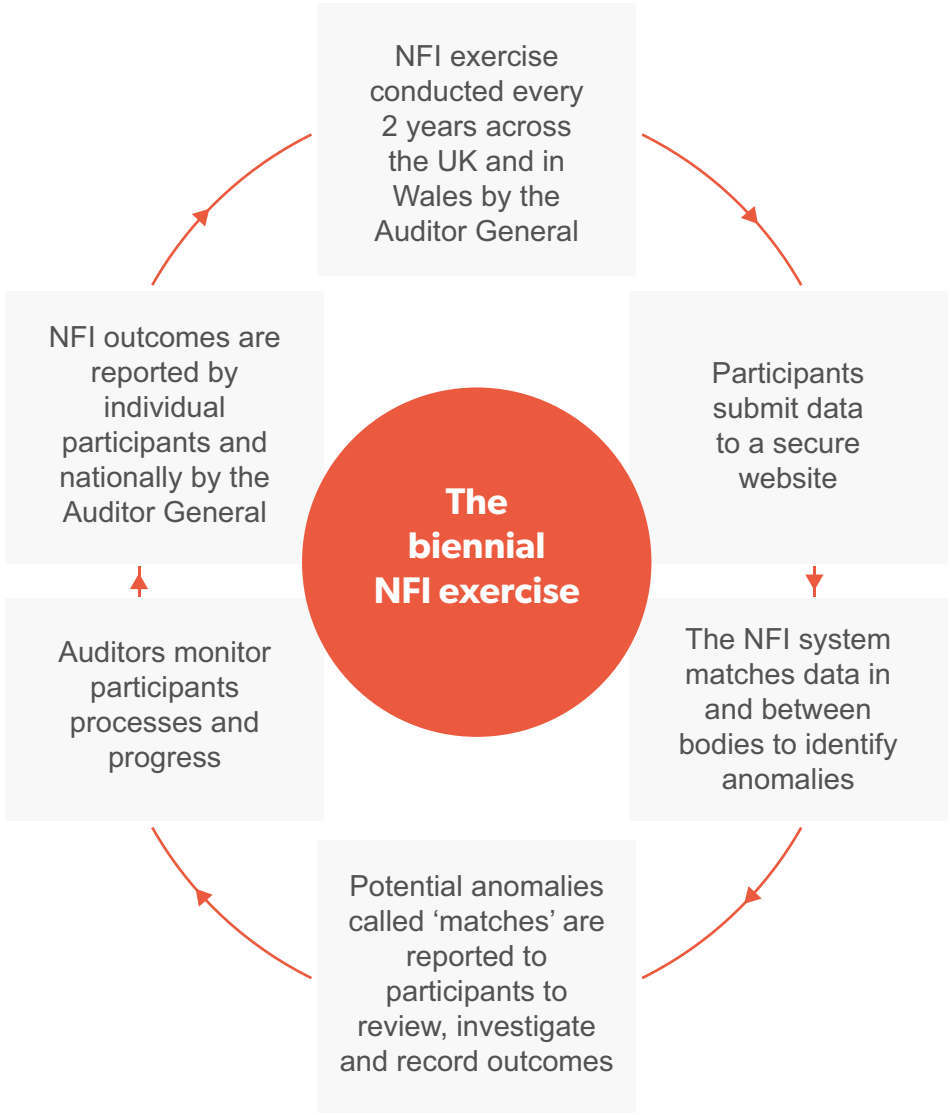
The NFI is a counter-fraud exercise across the UK public sector which aims to prevent and detect fraud. The Auditor General, Cabinet Office, Audit Scotland, and the Northern Ireland Audit Office lead the exercise in Wales, England, Scotland, and Northern Ireland, respectively. The NFI takes place biennially and enables public bodies to use computer data matching techniques to detect fraud and error.

The main purpose of the NFI is to ensure funds and services are provided to the correct people, but the NFI can also identify individuals entitled to additional services or payments eg housing benefit matches may identify customers entitled to council tax discount or reduction.

We carry out the NFI process under powers in the Public Audit (Wales) Act 2004. It is important for all parties involved that this exercise is properly controlled and data handled in accordance with the law. The Auditor General's Code of Data Matching Practice summarises the key legislation, and controls governing the NFI data matching exercise.

In Wales, the Auditor General has mandated unitary local authorities and NHS bodies to participate in the NFI. The Welsh Government, some Welsh Government Sponsored Bodies, and Audit Wales participate on a voluntary basis.



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How bodies work with the NFI

The success of the NFI is dependent on the proactivity and effectiveness of participant bodies in investigating the data matches.

Most participating Welsh public bodies managed their roles in the 2020-21 NFI exercise well.

However, some bodies could be far more pro-active in their approach to the NFI. In particular, some local authorities reviewed very few of the matches they received, and as a consequence did not do sufficient work to address potential frauds. This was due to some participants failing to recognise the importance of the exercise and/or an unwillingness to allocate adequate, skilled counter-fraud resources to investigate the NFI matches.

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Future developments

- The Auditor General is considering how to further develop the scope of NFI in Wales and areas of potential data-matching currently being explored include, housing tenancies, GP patient registration, business rates.
- The 2022-23 NFI is now underway. Data sets have been reviewed following a period of consultation and NFI participants are starting to submit data for matching.
- The Auditor General continues to work with the Welsh Government to promote and enhance participation in the NFI across Wales.

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

The Auditor General also audits local government bodies in Wales, conducts local government value for money studies and inspects for compliance with the requirements of the Local Government (Wales) Measure 2009.

The Auditor General undertakes the National Fraud Initiative in Wales under Part 3A of the Public Audit (Wales) Act 2004 which empowers him to conduct data matching exercises for the purpose of assisting in the prevention and detection of fraud in or with respect to Wales and to publish the results of any such exercise.

The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

For further information, or if you require any of our publications in an alternative format and/or language, please contact us by telephone on 029 2032 0500, or email info@audit.wales. We welcome telephone calls in Welsh and English. You can also write to us in either Welsh or English and we will respond in the language you have used. Corresponding in Welsh will not lead to a delay.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

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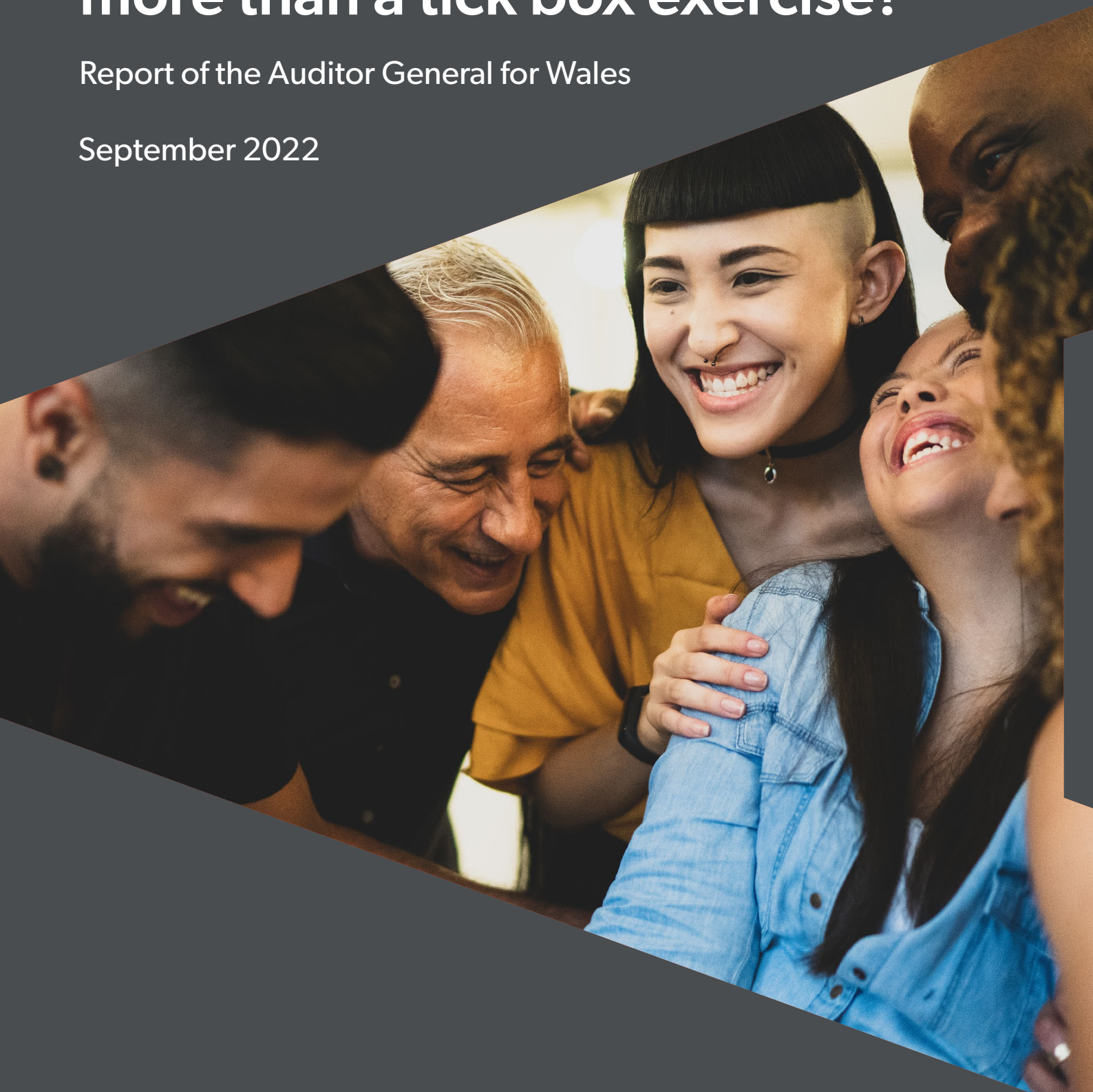
Equality Impact Assessments: more than a tick box exercise?

Report of the Auditor General for Wales

September 2022



This report has been prepared for presentation to the Senedd under section 145A of the Government of Wales Act 1998.

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

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Auditor General's foreword

Discrimination and inequality continue to impact on the quality of life and life chances of people in Wales. My Picture of Public Services 2021 report highlighted that the COVID-19 pandemic had amplified some of the entrenched inequalities in our communities. Black Lives Matter, MeToo and other social movements have brought issues of discrimination and inequality to the forefront of public policy and debate.

Equality Impact Assessment (EIA) is an important part of the approach to tackling inequality in Wales. EIAs help public services meet their legal duties to avoid discrimination in the decisions they make and to promote equality of opportunity and cohesion.

Done well, EIAs are more than a means to show compliance. They support the growth of a mind-set and culture that put issues of equality at the heart of decision-making and policy development.

Our work shows that within individual public bodies there are good examples of aspects of the process of conducting an EIA. Through this report, I want to help all public bodies learn from those that are doing well and trying new approaches.

However, what we have seen and heard tells us that public bodies in Wales tend to use their EIAs defensively. Too often, they seem like a tick box exercise to show that the body has thought about equality issues in case of challenge. While legal challenge is of course an important risk to manage, this approach means public bodies are not using EIAs to their full potential, especially in terms of promoting equality and cohesion.

I hope this report will be of interest to anybody involved in public services and with an interest in tackling inequality and promoting equality. However, I want this work to be more than interesting. It needs to have an impact. Specifically, I expect:

- the Welsh Government to respond to the recommendations to work with partners to improve and update the overall approach to EIAs;
- all public bodies to respond to the recommendation that they review their own approaches to EIAs, including mindset and culture, drawing on the findings of this report; and
- those involved in scrutiny to use this report to challenge their organisation's overall approach to EIAs and the quality of individual EIAs used to inform their decisions.

I am pleased to say that this work has already had positive impacts. Our fieldwork questions have prompted some public bodies to check aspects of their own arrangements. And we have shared emerging findings with some public bodies that were updating their approach to EIAs. Closer to home, at Audit Wales, we are looking closely at our own processes and procedures to reflect the lessons identified in this work.

Adrian Crompton
Auditor General for Wales

Key facts

We set out below some key facts about the population in Wales in the context of the nine protected characteristics under the Equality Act 2010.

26,754 pregnancies during 2021[8]

16.5% aged under 15[1]

3.9% people who identify as gay, lesbian, bisexual or other[6]

7.8% people from a Black, Asian or minority ethnic community[5]

50.1% people with religious belief[4]

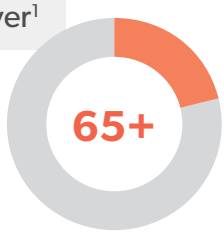
22.1% 16 to 64 year-olds identifying as disabled[2]

51.1% women[1]

48.1% people aged 16 and over who are married or in a civil partnership[3]

59% of transgender women and **56%** of transgender men said they avoided expressing their gender identity for fear of a negative reaction from others (UK)[7]

21.3% aged 65 and over[1]



3,107,500 population of Wales[1]

Sources:

1 Office of National Statistics (ONS), Population and household estimates, Census 2021, June 2022

2 StatsWales, Disability by age and sex (Equality Act definition) (2018-2020)

3 StatsWales, Marital status by age and sex (2018-2020)

4 StatsWales, Religion status by age (2018-2020)

5 ONS, Population estimates by ethnic group, England and Wales December 2021 (data for 2019)

6 StatsWales, Sexual identity by year, 2019

7 Government Equalities Office, National LGBT Survey, July 2018 (survey ran for 12 weeks from July 2017)

8 StatsWales, Initial assessment indicators for Wales, by mother's age, 2021

Key messages

Context

1 Tackling inequality is a long-standing goal of the Welsh Government. It features prominently in the 2021-2026 Programme for Government which includes the objective to 'celebrate diversity and move to eliminate inequality in all of its forms'[1]. The Well-being of Future Generations (Wales) Act 2015 makes 'A more equal Wales' a national goal. It defines this as 'a society that enables people to fulfil their potential no matter what their background or circumstances (including their socio-economic background and circumstances)'.

2 Equality Impact Assessment (EIA) is an important part of the approach to tackling discrimination and promoting equality in Wales. The Equality Act 2010 introduced the Public Sector Equality Duty (PSED) across Great Britain (**Exhibit 1**). The Welsh Government has made its own regulations[2] setting out some Wales specific duties that bodies listed in the Act need to follow to meet the PSED. Public bodies subject to the Act must assess the likely impacts of proposed policies or practices or proposed changes to existing policies or practices on their ability to meet the PSED. In doing so, they must comply with specific requirements to engage with groups likely to be impacted and monitor actual impacts.

1 Welsh Government, Programme for Government: update, December 2021
2 The Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011

Exhibit 1: the Public Sector Equality Duty and protected characteristics

The PSED requires public bodies, in exercising their functions, to have due regard to the need to:

- eliminate unlawful discrimination, harassment, victimisation, and any other conduct prohibited by the Act;
- advance equality of opportunity between people who share a protected characteristic and people who do not share it; and
- foster good relations between people who share a protected characteristic and people who do not share it.

The protected characteristics are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

The Act and the Wales specific duties apply to public bodies including councils, NHS bodies, fire and rescue services, national parks, education bodies (further and higher education bodies and maintained schools), and the Welsh Government and some of its sponsored bodies.

3 An EIA can provide evidence that the body has met the PSED. There have been legal challenges to decisions based on the lack or adequacy of an EIA. Moreover, EIAs support good policy and decision-making more generally by:

- **ensuring decisions impact protected groups in a fair way** – EIAs can demonstrate what, if any, action could be taken to mitigate the impact on one or more protected groups negatively affected by a decision and to promote equality and cohesion;
- **support evidence-based policy or decision-making** – EIA is a clear and structured way to collect, assess and present relevant evidence to support decisions; and
- **making decision-making more transparent** – EIAs must be published where they show there is or is likely to be a substantial impact.

4 As well as the PSED, the Equality Act 2010 included provision for a new socio-economic duty for public bodies[3]. The socio-economic duty came into force in Wales on 31 March 2021. It requires that public bodies, 'when making decisions of a strategic nature about how to exercise its functions, have due regard to the desirability of exercising them in a way that is designed to reduce the inequalities of outcome which result from socio-economic disadvantage'. The Welsh Government advises public bodies to consider the socio-economic duty as part of existing processes, including impact assessments. We are currently reviewing local government's work to tackle poverty, including aspects of the socio-economic duty and the lived experience of people experiencing poverty.

About this report

5 We looked at the overall approach to undertaking EIAs in public bodies in Wales. To focus our work, we concentrated on the 44 public bodies originally subject to the Well-being of Future Generations (Wales) Act 2015. The main groups covered by the PSED that we did not include were the education bodies – further and higher education institutions and maintained schools – and Corporate Joint Committees.

6 We focused primarily on understanding public bodies' approaches with a view to finding good or interesting practice and identifying any common areas for improvement. We did not evaluate individual public bodies' approaches in detail. **Appendix 1** has more detail on our audit approach and methods. Where we identify individual bodies' practices, this is not to say that they are necessarily alone in having good or interesting practices in that area.

7 Parts one to three of this report set out the findings from our consideration of the EIA process at the 44 public bodies. Below, we set out the main areas for improvement we identified. These include issues that go beyond how public bodies are conducting specific parts of the processes and offer insight about the overall approach to assessing the impacts of policies and practices and the underpinning mindset and culture.

8 The Welsh Government is currently reviewing the PSED Wales specific regulations. We have framed our key improvement areas and recommendations in the context of the opportunity the review offers to clarify aspects of the overall approach to EIAs in Wales.

3 The duty lay dormant on the statute book as the UK Government did not commence it. The Wales Act 2017 gave new powers to the Welsh Ministers and allowed them to commence the duty in Wales. It covers most types of public bodies subject to the PSED.

Key improvement areas

9 Positively, there are examples of good practice in aspects of the EIA process across the public bodies we looked at. There is also non-statutory guidance from the Equality and Human Rights Commission (EHRC)[4] and on the Equality Impact Assessment In Wales Practice Hub (the Practice Hub) about the detailed processes for conducting an EIA. Many public bodies use this guidance to shape their approaches. However, there are areas for improvement (**Exhibit 2**).

Exhibit 2: key improvement areas for EIA

	Greater clarity over which type of policies and practices must be impact assessed
	Greater clarity about the arrangements for assessing the impact of collaborative policies and practices
	Greater clarity about expectations to consider the PSED as part of an integrated impact assessment
	Better and more timely identification of the practical impacts of decisions on people and how different protected characteristics intersect
	More engagement and involvement of people with protected characteristics
	Better monitoring of the actual impacts of policies and practices on people
	A shift in the mindsets and cultures to move EIA away from being seen as an add-on ‘tick box’ exercise

4 Equality and Human Rights Commission, Assessing Impact and the Equality Duty: A Guide for Listed Public Authorities in Wales, October 2014; and Equality and Human Rights Commission, Technical Guidance on the Public Sector Equality Duty: Wales, August 2014.

Greater clarity over which type of policies and practices must be impact assessed

10 There is scope for the Welsh Government, working with partners, to clarify its expectations around which type of policies and practices must be impact assessed. As drafted, the Welsh specific duties require public bodies to assess all new policies or practices, or those under review. However, the EHRC's non-statutory guidance recognises that 'policies and practices' is a broad category and says public bodies may need to prioritise. It introduces the concepts of 'proportionality' and 'relevance', which it says public bodies can apply through a process known as 'screening'.

11 We think the current position is open to interpretation in terms of whether proportionality and relevance mean public bodies should: (a) prioritise big decisions, like budget decisions or major service change; or (b) prioritise decisions that are likely to have a big impact on certain groups, for example, small scale decisions could have a large impact on one section of the population. Further, many bodies have interpreted proportionality as determining the amount of work needing to be done to assess impacts, rather than whether a policy or practice needs an EIA.

12 The EIAs or screening decisions that public bodies publish are usually those that go to their boards or cabinets. They therefore tend to be at the more strategic or impactful end of the scale. While we did not examine in detail practices at individual bodies, we think there is a risk that public bodies may be informally filtering out smaller scale policies and practices that do not require decisions from boards or cabinet, even though they may impact on people with protected characteristics.

Greater clarity about the arrangements for assessing the impact of collaborative policies and practices

13 There is scope to clarify how public bodies should do EIAs in an environment of increasing collaboration. The law places duties on individual public bodies. Since the legislation came into force, public bodies are increasingly developing plans and delivering services through collaborative arrangements. The Welsh Government updated the legislation to extend the PSED and Wales specific duties to Corporate Joint Committees in local government, but there are other collaborative arrangements not covered. These include Public Services Boards and Regional Partnership Boards as well as multiple service specific collaborations.

14 The Welsh Government has not produced stand-alone guidance on the use of EIAs by collaborative arrangements, although guidance for Public Services Boards highlights EIA requirements for individual public bodies[5]. The EHRC's 2014 guidance predates the creation of many of these arrangements and offers high level advice that there should be a shared approach but does not say how this should work in practice.

Greater clarity about expectations to consider the PSED as part of an integrated impact assessment

15 Increasingly, public bodies are integrating their EIAs with other impact assessments. While there is no legal requirement to integrate assessments, the Welsh Government's guidance on the Well-being of Future Generations (Wales) Act[6] emphasises the opportunities for bodies to integrate their approach to different duties, including those under the Equality Act 2010. Many of the equality officers[7] we spoke to said that integrating impact assessments led to a streamlined process and a more rounded approach to thinking about impacts. The key downside can be that the assessment is longer and can appear daunting. Our review of EIAs also identified a risk that integrated impact assessments dilute the focus on the impacts of policies and practices on people with protected characteristics.

16 Public bodies are inconsistent in what they include in an integrated impact assessment. Mostly, they collate separate assessments in one document, rather than produce a truly integrated analysis of impacts. There is no specific guidance to support public bodies in conducting integrated impact assessments. Many equality officers would welcome clearer guidance from the Welsh Government about its expectations.

Better and more timely identification of the practical impacts of decisions on people and how different protected characteristics intersect

17 There are examples of EIAs that clearly identify likely impacts on groups of people. However, many EIAs we reviewed were descriptive. They identified that a policy or practice might impact on a group of people. But they did not show how it would impact people's lives in practice. This makes it more difficult for decision-makers to assess how important the likely impacts are and if any mitigating measures proposed would be sufficient.

5 Welsh Government, Shared Purpose: Shared Future Statutory Guidance on the Well-being of Future Generations (Wales) Act 2015 (SFSP 3: Collective Role (public service boards)), February 2016.

6 Welsh Government, Shared Purpose: Shared Future Statutory Guidance on the Well-being of Future Generations (Wales) Act 2015 (SFSP 2: Individual Role (public bodies)), February 2016.

7 We have used the term 'equality officer' throughout this report to refer to staff in public bodies with specific lead specialist roles for equality, whether that be their full-time job or part of their role. The way these roles are structured, and their seniority, varies.

18 In general, public bodies tend to identify negative impacts that they need to mitigate where possible. They are less likely to identify potential ways that the policy or practice could positively promote equality of opportunity and cohesion, even though this is a requirement of the PSED.Few public bodies have fully grasped the complexity of identifying likely impacts of policies and practices. None of the EIAs we looked at considered what is known as 'intersectionality'; the way that different protected characteristics combine. For example, while an EIA may identify impacts for Muslim people, it may not recognise that impacts could be very different for a Muslim woman compared to a Muslim man.

19 Many public bodies are thinking about how to identify the cumulative impacts of multiple decisions but few are doing so. Most do not have supporting systems that would enable those conducting EIAs to access the information needed about other decisions.

20 Most public bodies' formal processes and guidance say they will start thinking about impacts very early in the policy development process. However, many of the equality officers recognised that in practice EIAs often start late in the process, sometimes very shortly before a decision is due to be taken. This reduces the scope to shape the policy or practice and to mitigate impacts.

More engagement and involvement of people with protected characteristics

21 There are examples of public bodies seeking views from people with protected characteristics and drawing on their lived experience as part of the EIA. However, some third sector bodies are concerned that this does not happen nearly enough. We found that where public bodies seek views these often form part of a broader open consultation rather than focussing on specific groups with protected characteristics.

22 Some third sector organisations said that listening to people with protected characteristics was the action that would most improve EIAs. National representative public bodies could not always respond to the number of requests to take part in EIAs they receive and did not always have knowledge or information to respond to local issues.

Better monitoring of the actual impacts of policies and practices on people

23 Public bodies need to do more to monitor the impact of policies or decisions on protected groups. Equality officers at individual public bodies identified very few examples of public bodies monitoring the actual impacts of a policy or decision once implemented. Those examples put forward generally reflected broader monitoring of a policy's objectives rather than whether the impacts identified in the EIA materialised or whether there were other unanticipated impacts.

A shift in the mindsets and cultures that moves EIA away from being seen as an add-on 'tick box' exercise

24 From what we have seen there has not been a sufficient change in the mindset and culture in public services to put issues of equality at the heart of policy making. The mindset revealed by the EIA is often defensive: using EIAs to prove the body has paid due regard to equality in case of political or legal challenge. Often, the EIA seems like an additional 'tick box' exercise to be complied with rather than a tool to promote equality.

4 Recommendations

Recommendations

Clarifying the scope of the duty to impact assess policies and practices

R1 There is scope for confusion about which type of policies and practices must be subject to an assessment for their impact on the public sector equality duty. **The Welsh Government should clarify its interpretation of the duty, including whether and how it expects public bodies to apply any test of proportionality and relevance.**

Building a picture of what good integrated impact assessment looks like

R2 Many public bodies carry out integrated impact assessments that include consideration of the PSED alongside other duties. But practice is inconsistent and often involved collating multiple assessments in one place, rather than being truly integrated, **to help maximise the intended benefits of integrated impact assessments, the Welsh Government should work with key stakeholders with an interest in the areas commonly covered by integrated impact assessments and those with lived experiences, to share learning and work towards a shared understanding of what good looks like for an integrated impact assessment.**

Recommendations

Applying the equality duties to collaborative public bodies and partnerships

R3 The public sector landscape has changed since the introduction of the PSED and the Welsh specific duties, with an increasing focus on collaborative planning and delivery. **The Welsh Government should review whether it needs to update the Wales specific regulations to cover a wider range of collaborative and partnership arrangements. These include public services boards, regional partnership boards and other service specific partnerships.**

Reviewing public bodies' current approach for conducting EIAs

R4 While there are examples of good practice related to distinct stages of the EIA process, all public bodies have lessons to learn about their overall approach. **Public bodies should review their overall approach to EIAs considering the findings of this report and the detailed guidance available from the EHRC and the Practice Hub. We recognise that developments in response to our other recommendations and the Welsh Government's review of the PSED Wales specific regulations may have implications for current guidance in due course.**

Supporting arrangements for conducting EIAs

01

1.1 Conducting an EIA can be complicated. Good support can help make the process of conducting EIAs easier and more effective by having a clearly spelled-out approach and process, underpinned by clear guidance and training. And public bodies can have expert advice to hand to support those involved in assessing the impacts of decisions.

Setting out the organisation's approach to EIA

What we looked for

A clearly spelled-out approach to EIA for the organisation, including whether the EIA should form part of a wider integrated impact assessment.

What we found

Almost all public bodies had a set process for conducting an EIA, although these vary from a stand-alone EIA to producing integrated impact assessments covering a wide and varying range of other legal duties and policy priorities.

Strategic equality plans

1.2 All 44 public bodies met the requirement to produce a Strategic Equality Plan (SEP). The SEP must include an organisation's equality objectives, how they will measure progress on meeting objectives, and how they will promote knowledge and understanding of the general and specific duty. The SEP must also set out the public bodies' arrangements for assessing the likely impact of policies and practices on their ability to meet the PSED. However, in our review of SEPs we found that only 17 of the 44 bodies did so and to varying degrees of detail.

1.3 A few public bodies have gone further than simply describing arrangements. For example, Conwy County Borough Council's SEP describes in detail its process for EIA, how its Cabinet uses EIAs to support decision-making, and scrutiny committees' role in ensuring the quality of EIAs. The Council's SEP also explains how it has used EIAs to inform its equality objectives.

Organisational approach – integrated and stand-alone assessments

1.4 Nearly all public bodies (42 of 44) have a set process for undertaking EIAs. Most said that they put information on intranet sites, alongside supporting documents, contacts and most often a Word template for completion. Our review of EIAs found no standard format across public bodies, although most closely followed the approach set out in the Practice Hub. Members of the North Wales Public Sector Equality Network[8] have worked together to develop a standard template which most members of the network have adopted at least in part.

1.5 In around two-thirds (30 of 44) of public bodies we spoke to, the EIA forms part of a wider integrated impact assessment. There is no common approach to integrated impact assessments and no national guidance on what should be covered. There are some assessments that public bodies commonly include alongside the PSED (**Exhibit 3**). Some include other legal duties as well as policy priorities and practical considerations, such as finance. For example, the Welsh Government's integrated impact assessments sometimes cover climate change impacts, health impacts and economic impacts as well as a wide range of other legal duties, depending on the nature of the policy or practice.

8 The North Wales Public Sector Equality Network is an informal network of public bodies working together to advance equality. Representation includes North Wales local authorities, Betsi Cadwaladr University Health Board, North Wales Police and Police Authority, North Wales Fire and Rescue Service, Welsh Ambulance Services NHS Trust, and Snowdonia National Park Authority.

Exhibit 3: assessments commonly included in an integrated impact assessment alongside the EIA

Well-being of Future Generations	The Well-being of Future Generations (Wales) Act 2015 introduced seven well-being goals for Wales. It also established the sustainable development principle and five ways of working – long-term, integration, involvement, collaboration, and prevention – to demonstrate application of the principle. An integrated impact assessment may also include an assessment of the policy or practice against the seven goals, public bodies' individual well-being objectives and/or the five ways of working specified in the Act.
Welsh Language	The Welsh Language (Wales) Measure 2011 declares that the Welsh language has official status in Wales. It makes provision to promote and facilitate the use of the Welsh language and to treat Welsh no less favourably than English through the Welsh language standards. Part of applying the standards means that public bodies must consider the effects their policy decisions on the Welsh language.
Environmental impacts	There are various duties to carry out environmental impact assessments depending on the nature of the proposed policy or practice. These range from strategic assessments of plans and programmes to assessments of projects that potentially impact on habitats and biodiversity.
UN Convention on the Rights of the Child	The Rights of Children and Young Persons (Wales) Measure 2011 embeds consideration of the United Nations Convention on the Rights of the Child and the optional protocols into Welsh law. The UN Convention consists of 41 articles, which set out a wide range of types of rights including rights to life and basic survival needs, rights to development including education and play, rights to protection, including safeguarding from abuse and exploitation, and rights to participation and express opinions.

Socio-economic	The Socio-economic duty came into force on 31 March 2021. When making strategic decisions, such as deciding priorities and setting objectives, public bodies must consider how they can reduce inequalities associated with socio-economic disadvantage.

1.6 Most integrated impact assessments involve collating separate impact assessments into a document template. Few seem to be a truly integrated impact assessment. Some public bodies are trying to make the connections between assessments and reduce duplication. For example, Carmarthenshire County Council, Powys County Council, Gwynedd Council, Denbighshire County Council and Wrexham County Borough Council have each developed, or are developing, an IT solution to bring together the relevant information needed to inform an integrated impact assessment.

1.7 Very few public bodies solely assess the impact on the PSED even when they do not consider their assessments to be integrated. In those public bodies that report having a standalone EIA process, the EIA often also includes Welsh-language and socio-economic impacts.

1.8 Previous research has found length is a barrier to the use of impact assessments in decision-making[9]. It was hard for us to judge any EIA or integrated impact assessment as too long as many factors affect the length including the nature of the policy or decision and the number of assessments undertaken. We reviewed some documents that were very long; for example, the integrated impact assessment of the Welsh Government's remote working policy was 45,000 words (average reading time 2.5 hours). The majority for which a word count was easily identifiable ranged between 2,500 and 7,500 words (average reading time 8 to 25 minutes).

1.9 Most public bodies that have chosen not to integrate their assessments had considered the option. Reasons for not integrating assessments included a concern that there would be insufficient regard to the PSED. This may be a valid concern. Our review suggests that, in some cases, the PSED is covered in limited detail and appeared secondary to other considerations even though all the public bodies we spoke to who conduct integrated impact assessments felt they sufficiently covered the equality element.

9 Grace, C., Reducing Complexity and Adding Value: A Strategic Approach to Impact Assessment in the Welsh Government, Public Policy Institute for Wales, February 2016.

Specialist support and expertise

What we looked for

That there is specialist support and expertise available in the organisation to those conducting EIAs.

What we found

In most cases, policy leads are responsible for conducting EIAs and can access support from colleagues with knowledge in equality related issues and an in-depth understanding of the organisation's process for conducting an EIA.

1.10 In almost all public bodies, responsibility to undertake an EIA lies with the lead officer developing or reviewing a policy or practice. This is partly pragmatic, due to the number of EIAs public bodies conduct. Equality officers told us this approach meant that EIAs benefitted from policy leads' expertise on the topic area. However, they identified drawbacks, including the difficulty of ensuring consistency, getting EIAs started at the right time and ensuring quality.

1.11 All public bodies have equality officers (or equivalent) with knowledge in general equality issues and a detailed understanding of the organisation's EIA process. In all public bodies, staff conducting EIAs can ask equality officers for guidance when required. EIAs are mostly conducted without the input of an equality officer. The process at Aneurin Bevan University Health Board is one exception to this, where the first step for anyone who thinks they need to undertake an EIA is to contact the Equality Diversity and Inclusion specialist to discuss the proposed policy or practice and agree what actions they need to take, with ongoing support also provided. In smaller public bodies, where an EIA is more likely to relate to staff policies and decisions, the lead for conducting the EIA is frequently an HR officer who is also the equality officer.

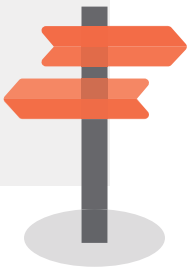
Guidance to support those conducting an EIA

What we looked for

That there is guidance to support those conducting an EIA, setting out what they need to do and when, in line with the duties and their organisation's chosen approach.

What we found

There is non-statutory national guidance and support available setting out some good practice in the stages of an EIA, although there are gaps, notably in terms of integrated impact assessments. Most public bodies have also produced their own guidance to support their EIA process.



External guidance

1.12 The Welsh Government has not published statutory guidance on the application of the PSED in Wales or the Welsh specific duties. The EHRC published non-statutory guidance on the Welsh specific duties in 2014. Welsh Government guidance encourages public bodies to integrate different duties. But there is no specific national guidance on how to conduct integrated impact assessments and what should be included.

1.13 The Welsh Government, Welsh Local Government Association, and NHS Centre for Equality and Human Rights jointly developed the Practice Hub in 2015-16. This online resource provides information and support to public bodies in Wales to undertake EIAs. It provides a detailed eight step guide to good practice in undertaking EIA and gives information on the Welsh specific duties.

Internal guidance

1.14 Internally, most public bodies have produced guidance to support their EIA process. The format and detail of the guidance and quality vary across public bodies. Some provide step-by-step guidance which outlines the process and steps for completing an EIA. Some embed practical information and links within templates.

1.15 A few public bodies do not provide guidance on their individual processes. Some of these provide direct one-to-one support from an equality officer (or equivalent) to the individual completing the assessment. Others signpost staff to the external guidance on the Practice Hub.

Training

What we looked for

That training on conducting an EIA is available for staff involved in developing EIAs and those that use them for decision-making.

What we found

Most public bodies offer training to those involved with EIAs through a variety of media.

1.16 Around two-thirds (31 of 44) public bodies we spoke to provide formal training to officers who are likely to complete or have an interest in EIA. This training frequently extends to elected members, board members and decision-makers.

1.17 Methods of training vary. Some offer face-to-face delivery of training, with much of this via video calls since the start of the COVID-19 pandemic. Many public bodies include online modules and e-learning tools on equality, and EIAs as part of their general staff training. Those public bodies that do not offer formal training nevertheless provide one-to-one support to individuals conducting EIAs and upskill them through the process.

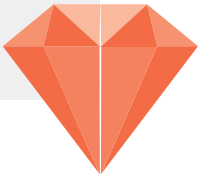
Quality assurance

What we looked for

An approach to ensuring the quality of the EIA process.

What we found

Half of public bodies had an approach to quality assurance, which varied from a simple sign-off on individual EIAs to more comprehensive peer learning to support improvement of the whole EIA process.



1.18 Half (22) of the public bodies have a quality assurance process in place for their EIA. The approach varies greatly. For some, quality assurance is about the quality of individual EIAs. Some require an EIA to be signed off by a senior officer. In Cardiff and Vale University Health Board, the lead officer conducting the EIA will work with an equality officer and a representative from Public Health Wales to review and interrogate the content of the EIA during its development. Other public bodies have begun to take a 'peer review' approach to developing EIA with input from experts from across the organisation.

1.19 A small number of public bodies use quality assurance to test the quality of their overall approach. For example, the Arts Council of Wales conducts an annual sample review of EIAs and uses the findings to improve the process.

Assessing impacts

02

2.1 The Wales specific duties require listed public bodies to assess the likely impact of proposed policies and practices, or those under review, on their ability to comply with the PSED. In doing so, they must have regard to certain types of information that they hold and meet specific requirements to engage with people or organisations that represent people with one or more protected characteristics. EHRC guidance and the Practice Hub set out in detail the steps public bodies can take to fulfil these requirements.

Screening

What we looked for

A clear approach to determining if an equality impact assessment is required.

What we found

Just over half of public bodies have a process for screening although many have stopped using screening, some due to risk of confusion or 'gaming' by staff.

2.2 There are no statutory exemptions setting out policies and practices that do not need to be assessed. However, the EHRC guidance and the practice hub include a 'screening' process to determine which policies or practices should have a full EIA.

2.3 Just over half (24 of 44) of public bodies we spoke to said that they have a screening process. Screening is most often a document template which an officer developing or reviewing a process or policy uses to determine whether they anticipate any impact on protected groups. The approach ranges in practice from a separate short impact assessment to a set of screening questions at the beginning of the full assessment template which determine whether to proceed with the full EIA.

2.4 Where a body decides it does not need a full EIA, they will usually retain a copy of the screening tool as evidence that it has considered the PSED. Most public bodies with a screening process will document the decision not to go ahead with a full EIA in the supporting papers that go to the cabinet or board.

2.5 Most often, the policy lead keeps the detailed record of screening. However, a few public bodies are trying to strengthen practice and ensure central records are maintained. For example, Cardiff Council has developed an online assessment tool to support policy leads through the process and encourage consideration of impact at the earliest stages of policy development. As well as sending advice and guidance to the officer completing the online assessment, the tool also sends a copy of the screening information to the equality officers.

2.6 The 20 public bodies who do not have a screening process had often consciously removed the screening step. Many said screening was an unnecessary step, as there are very few of their decisions that will not have potential to impact on the PSED. Some public bodies said that there was also scope for confusion, with lead officers completing a screening form, thinking it was an EIA. Others were concerned that some officers may 'game' the process: tailoring their responses to screening in a way designed to result in a decision that no further assessment was required.

2.7 Those public bodies that do not have a screening process usually provide additional guidance or a process chart, clarifying when to conduct a full EIA. All public bodies also offer the lead officer an opportunity to consult with an equality officer.

Timing

What we looked for

EIAs being started at an early stage to inform the development of a policy or decision.

What we found

All public bodies intend to carry out an EIA as early as possible, but many recognise this is often not the case in practice, and in some cases EIAs are very late in the policy development or decision-making process.

2.8 All 44 public bodies intend that EIAs should be started as early in the development or review of a policy as possible. But many public bodies acknowledged that this often does not happen in practice.

2.9 The timing of EIAs is affected by whether policy leads know that they are required to do an EIA and if resources – staff and time – are available at the appropriate point. Sometimes, if public bodies must make decisions very quickly, they either do not do an EIA or do them late in the decision-making process. This can be too late to consider changing a policy to lessen any possible negative impact or to build on positive impacts.

2.10 Decisions at the start of the COVID-19 pandemic were often made without an EIA. This reflected the urgency of decisions but meant that the impact on vulnerable people was not formally assessed. In August 2020, the Senedd's Equality, Local Government and Communities Committee[10] recommended that the Welsh Government should ensure that each major policy or legislative decision is accompanied by an effective equality impact assessment, and an analysis of the impact on human rights. The Welsh Government accepted the recommendation, and since August 2020 has published dozens of impact assessments related to the COVID-19 pandemic on its website.

10 Senedd Equality, Local Government and Communities Committee, Into sharp relief: inequality and the pandemic, August 2020.

2.11 In most public bodies, papers accompanying decisions that go to cabinets or boards contain a box or section that refers to consideration of the equality duties. This serves as a backstop to prevent public bodies from making decisions without any regard to the duties, even though this generally would be very late in the process.

Use of evidence

What we looked for

Use of a range of evidence to support the assessment, including the views of those likely to be impacted and data on lived experience.

What we found

Public bodies use a mix of evidence, although there are gaps in available data on some protected characteristics and the inclusion of the views and lived experiences of people with protected characteristics is patchy.

Quantitative data

2.12 EIAs need a sound evidence base to inform their conclusions. The depth and detail of the information base vary across organisations and by assessment The depth of information and analysis often depends on the scale of the decision and the availability of relevant and specific evidence.

2.13 All public bodies expect to include some quantitative data, such as demographic information or service level data. Around two-thirds (29 out of 44) of public bodies include at least some examples of internal information sources and point to publicly available data in their guidance and templates. Some go further. For example, Merthyr Tydfil County Borough Council includes in its guidance a detailed list of sources where policy leads can find relevant evidence, with embedded links to external data sources.

2.14 There are some significant data gaps in the data that is available to public bodies. Generally, there is little information available about some protected characteristics, particularly sexual orientation, gender reassignment, and pregnancy and maternity. Data that is available at a national level is sometimes not available at a health board, council, or ward level, which makes it difficult for public bodies to understand their local populations with protected characteristics.

Qualitative information

2.15 The inclusion of qualitative information based on the views and experiences of people with protected characteristics is also patchy. When introducing new policies or changing services public bodies often undertake a consultation exercise. In the examples we saw, these were often targeted to the public in general, and it was difficult to see if the public body had sought to engage specifically with people from protected groups.

2.16 Nonetheless, we did see examples of EIAs where evidence from engagement with groups was covered. For example, when Snowdonia National Park Authority undertook an EIA on its communication and engagement strategy, the assessment considered how the strategy could engage with people who speak languages other than English or Welsh. It also considered impacts on those who were digitally excluded, a group that is more likely to include older people and more women than men.

2.17 Some respondents to our general call for evidence said that drawing more on the views and experience of people with protected characteristics would improve the quality of EIAs. This includes engaging with individuals and grassroots organisations as well as national organisations representing protected groups. Some respondents said that public bodies should do more to publicise consultations by a range of means, including but not restricted to social media.

2.18 Some all-Wales third sector bodies responding to our call for evidence said that they were often asked to provide views for EIA and that some cannot respond to all the requests they receive. Sometimes they do not have information on local services and impacts.

2.19 A few public bodies are trying to draw on the lived experience of people with protected characteristics through different forms of consultation. Some use existing networks for staff with protected characteristics to understand different perspectives. Others, draw on existing relationships with third sector groups to understand the lived experience.

Identifying and mitigating likely impacts

What we looked for

Clear identification of likely impacts, including positive impacts in promoting equality, as well as negative ones.

Some consideration of cumulative impacts arising from other decisions that impact the same group or groups and how different protected characteristics combine (intersectionality).

Clear recommendations for mitigating negative impacts that have been acted on before the decision is made.

What we found

While there are examples of public bodies identifying specific impacts, often EIAs describe impacts in very broad terms. Very few identify the cumulative impacts of multiple decisions on groups or consider how different protected characteristics intersect. Very few can show how recommendations for mitigating impacts are followed through.

Specific impacts

2.20 Positively, our review of EIAs found examples of public bodies clearly identifying specific likely impact of policies or practices on protected groups. However, many EIAs included statistics to describe the population of people with protected characteristics without being clear how the policy or practice would likely impact on them. We also observed a tendency for EIAs to focus on negative impacts, thereby missing positive impacts and opportunities to improve cohesion and reduce inequalities.

2.21 We found that most EIAs reviewed provided data and information on each protected group separately. For example, the EIA on Conwy County Borough Council's Older Peoples' Domiciliary Care Finance and Commissioning Project set out the likely impact on people with each protected characteristic.

2.22 Most public bodies' approaches to EIA involve making recommendations to overcome negative impacts. Public bodies should incorporate mitigating actions into the policy development process, recognising it is not always possible to mitigate all negative impacts, such as with reductions in service. Very few public bodies have a process in place to track whether they have implemented the mitigating actions, after a decision is taken. In Hywel Dda University Health Board, the EIA has an associated action plan with a review date. In Aneurin Bevan University Health Board the Equality, Diversity, and Inclusion specialist keeps a database of actions arising from EIAs for monitoring purposes.

Intersectionality

2.23 Increasingly, it is understood that inequality is intersectional. People's characteristics interact in a complex way to give a unique experience of inequality. For example, the experience of a Muslim woman cannot separate 'female' and her experience as a Muslim. It will differ from that of a Muslim man and of a non-Muslim woman. However, we did not see examples of such nuanced understandings of inequality in the examples we reviewed.

Cumulative impacts

2.24 Public bodies in Wales make many decisions each year that, taken together, can be very detrimental to people from protected groups. For example, one respondent to our call for evidence gave the example of how individual decisions to reduce or close facilities and services such as public toilets, library services, day centres, and bus services had a cumulative impact on many older people who use the services. They said that, while each individual decision might not be significant, together they meant that some older people were becoming isolated.

2.25 The few instances we found where public bodies have begun to give thought to cumulative impacts tend to be when public bodies are making several decisions at the same time. For example, councils usually undertake a cumulative approach to assessing the impacts of their proposed budget each year. Individual service changes being proposed because of budget changes are assessed simultaneously allowing a better overview of potential impacts for the budget.

2.26 Typically, however, public bodies make decisions separately. One of the respondents to our call for evidence to decision-makers highlighted that it is difficult in principle to predict the likely impacts of multiple decisions in a complex landscape. Practically, the ability to take account of impacts from other decisions relies on the policy lead knowing about other decisions within an organisation and having access to the EIAs. A small number of public bodies are trying to address this information gap by using an IT solution to undertake the EIA (**paragraph 1.6**). This way, the assessment of impact for each policy change and decision is held centrally, making it easier for policy leads to bring together the information.

Decision-making

What we looked for

That the EIA and likely impacts it identifies are considered at the point of decision-making.

What we found

Equality officers' views varied around the extent to which their organisations prioritised the EIA in decision-making. Most respondents to our general call for evidence said public bodies did not pay sufficient regard to protected characteristics. The small number ofresponses from decision-makers suggest a view that the EIA is seen as a 'tick box exercise'.

2.27 The consideration given to EIAs in decision-making varies across public bodies in Wales. In general, equality officers felt that decision-makers take assurance in knowing that the policy lead has completed an EIA. Decision-makers will have access to a summary or the complete EIA accompanying each decision in their cabinet or board papers.

2.28 The equality officers we spoke to had mixed views over the extent to which their organisations placed sufficient weight on the EIA in decision-making. Over three-quarters of respondents to our general call for evidence who answered the question (29 of 37) disagreed that public bodies in Wales give appropriate due regard to people with protected characteristics when developing policies or making changes to services.

2.29 Generally, equality officers were not aware of instances where decision-makers challenged the content or recommendations of an EIA at the point of decision. Most felt that the accompanying EIA should have considered and shaped the policy sufficiently that there would be no need for such challenge at that late stage.

2.30 We only received ten responses to our call for evidence from decision-makers. While it is hard to draw conclusions from such a limited evidence base, it is notable that three of the ten referred to EIAs being used like a ‘tick box’.

Reporting and monitoring impacts

03

3.1 Public bodies must publish reports of the assessments where they show a substantial impact (or likely impact) on their ability to meet the PSED. They must also monitor the actual impact of the policies and practices subject to an equality impact assessment.

Reporting

What we looked for

Public information about decisions and a clear description of how the EIA has influenced the decision-making.

What we found

Most public bodies publish some of their EIAs as part of a wider set of papers and they are often not easy to find.

3.2 Almost all public bodies in Wales publish their EIAs, at least in part. Typically, they publish EIAs with decision-related papers, such as cabinet or board papers. There is usually a section on the body's website which holds all the papers for each meeting and is accessible to the public[11]. There are a few exceptions in some of the smaller public bodies, who do not routinely publish their EIAs.

3.3 It can often be difficult to find EIAs which relate to a specific decision on public bodies' websites. The EIAs which feature more prominently and are easier to locate often relate to strategic decisions such as budgets or key corporate strategies. Newport City Council have tried to bring EIAs into a central location on their website to make them more easily accessible, while recognising that this approach relies on the individuals completing EIAs sharing them for publication, which sometimes does not happen.

11 In some instances, bodies do not publish EIAs if they form part of a paper that is held back from publication due to its confidential or sensitive nature. However, these EIAs can sometimes be obtained via a Freedom of Information request if someone has a particular interest in seeing them.

Monitoring impacts

What we looked for

A clear approach to monitoring the impacts of the decision after it is implemented, including those identified as part of EIA as well as any unexpected impacts.

What we found

Very few public bodies monitor the impact of the decisions in the context of the PSED.

3.4 Some public bodies require those completing EIAs to identify a review date when monitoring is supposed to occur. We saw examples where EIAs set out plans for monitoring. For example, a Powys Teaching Health Board EIA included plans for monitoring service use after a change in surgery opening hours and for and independent evaluation of the service change. Also, Conwy County Borough Council's EIA for its review of domiciliary care included detailed arrangements for monitoring the impact using data and information that are routinely reported, including individual feedback from people receiving care.

3.5 However, equality officers had seen little evidence of the impact of policies and practices being monitored in light of the EIA. Those public bodies that outlined a monitoring process were often referring to the monitoring of an implementation of a policy or practice against its objectives or targets, not the impact that the decision had on people with protected characteristics.

3.6 In general, public bodies do not consider the impacts of policies and practices in terms of the PSED until there is another decision due on the same policy or practice. At that point, the body conducts a new EIA. Many of the equality officers we spoke to seemed unsure about how, in practice, they would monitor the impact of a decision on protected groups and would welcome more guidance.

Challenging EIAs

What we looked for

That the organisation identifies and applies lessons from any challenge to decisions on the basis of equality or the quality of the EIA.

What we found

Many equality officers did not think there had been any challenges to EIAs conducted by their organisation, but where there has been challenge some public bodies are using it as a learning opportunity.

3.7 Decisions made by public bodies can be challenged based on the EIA. Public bodies that do not have a clear record showing that they have considered the likely impacts of their decisions for people with protected characteristics leave themselves open to challenge. This could potentially include a judicial review. Some equality officers did not know what process someone would use to challenge an EIA. The majority said that any challenges would go through their general complaints process, with the involvement of the relevant service, equality officers and legal team.

3.8 Many equality officers thought there had not been any challenge to an EIA conducted by their organisation. Those that were aware of challenge taking place said that it was something that happens infrequently. Almost half of respondents to our general call for evidence who answered the question (17 of 35) said they had challenged some aspect of an EIA. We do not know if this was a formal or informal challenge.

3.9 Equality officers who had experienced challenge to an EIA said their organisation can resolve the issues either by making changes to a policy or practice, or by providing evidence that they had considered the impacts. Respondents to our general call for evidence gave examples of issues they raised being resolved. For example, one had objected to the EIA conducted on a new bus interchange because the council had not sought the views of people with protected characteristics on the proposals. Following their intervention, people with low vision visited the site and suggested changes to make the interchange more accessible.

3.10 While there are positive examples of public bodies responding to challenge, several respondents to our general call for evidence who had challenged aspects of an EIA reported not receiving any response to their challenge. A few equality officers told us that their organisation had learnt from the experience of having an EIA challenged. One had used examples of challenge from other public bodies to inform its EIA training as a particularly useful way of making impacts more easily understood to lead officers conducting EIAs.

Appendices

1 Audit approach and methods

1 Audit approach and methods

Audit approach

Our main aim was to provide insight about the approach to EIAs undertaken across the public sector in Wales. We wanted to highlight good practice and identify opportunities to improve. To help shape our thinking about what good practice to look for, we drew heavily on existing guidance materials, in particular that produced by the Equality and Human Rights Commission (EHRC) and the Equality Impact Assessment in Wales Practice Hub hosted by Public Health Wales NHS Trust.

We set out to explore to what extent public bodies have integrated their approach to undertaking EIAs, including the new socio-economic duty and the cumulative impact of decisions. We also explored what difficulties public bodies experience that affect the quality and timeliness of EIAs. We looked at how public bodies monitor the impact of decisions on their population. Each of the sub-sections in the main body of this report describes what we were looking for through our work.

In looking across the public bodies, we focused on the 44 public bodies originally subject to the Well-being of Future Generations (Wales) Act 2015. The Auditor General for Wales is the external auditor of each of these bodies, which include local authorities, health boards and some NHS trusts, national parks, and fire and rescue services. They also include the Welsh Government and some of its sponsored bodies. Our audit coverage did not include education bodies – further education, higher education or maintained schools – that are subject to the PSED. It also did not include the four Corporate Joint Committees (CJCs) established by the Local Government and Elections (Wales) Act 2021 and which are subject to the PSED.

Audit methods

Document review: We reviewed documents from each of the 44 public bodies, including those relating to the equality plans and details of the organisation's EIA process. We also reviewed details of their process for integrated impact assessments. We reviewed a sample of 29 EIAs provided by public bodies: 11 by local authorities, eight by health bodies, two fire and rescue, two national parks and six by the Welsh Government or its sponsored bodies.

Interviews: We interviewed the equality officers or their equivalent in each of the 44 bodies. We have used the term 'equality officer' throughout this report to refer to staff in public bodies with specific lead specialist roles for equality, whether that be their full-time job or part of their role. The way these roles are structured, and their seniority, varies.

Call for evidence: We sought wider views about people's experience of EIAs through a call for evidence between October 2021 and June 2022. We publicised this generally and in particular to third sector organisations. We received 40 responses, 23 from individuals and 15 responding on behalf of an organisation (two did not say).

We also sought the views of decision-makers through a separate call for evidence open between February and June 2022. We received ten responses (eight from individuals working in local authorities, one health and one fire and rescue).

While the responses we received to the calls for evidence are not necessarily representative of individuals, the third sector or decision-makers, they have provided useful detail which we have included through the report and which informed our overall analysis.

Stakeholder engagement: The EHRC is responsible for promoting and enforcing equality and non-discrimination laws. We met with officials in the EHRC Wales Team regularly throughout our work, discussing our scope and emerging findings. We also met with the Welsh Local Government Association's equality network and the Chair of the All-Wales NHS Equality Leadership Group. We interviewed officials from the Welsh Government with responsibility for equality policy.

Wider audit intelligence: We drew on existing intelligence from our local financial and performance audit work, where that was relevant to equality impact assessments.

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Website: www.audit.wales

Audit and Assurance Recommendations and Management Responses

What are audit recommendations / management responses?	Audit and Assurance (Internal audit) is in a privileged position to highlight (a) what expected controls to manage / mitigate risk should be, (b) what are the current controls in place, and (c) suggest what can be done to remediate gaps, issues or improve the way activities are completed. We complete this through individual audits, determined by an annual Internal Audit Plan, which is approved by the Audit, Risk and Assurance Committee. An internal audit is 'an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.' With remediation or improvements, these usually take the form of recommendations detailed within internal audit reports. Management set out in the form of responses how they will implement / address and close-out the audit recommendations.
Do we track all recommendations?	All recommendations are tracked by the Health Board. Every year Audit and Assurance undertake a follow-up review of the progress of all significant recommendations / management responses reported on. The conclusions are reported to the Audit, Risk and Assurance Committee and the tracking of recommendations may be updated / amended accordingly.
Is a response required for each recommendation?	Yes – a management response is required for each recommendation raised by Audit and Assurance.
What should be included in a management response?	Details of the action to be taken. These do not need to include lengthy comments or explanations as clarity of the action to be taken and management commitment is usually key. They should be **SMART** responses and in particular: **Specific** – What action management will take to implement the recommendation. **Measurable** – Management should note exactly what evidence will be available to demonstrate their completion of each recommendation e.g. a new policy will be in place. **Attainable** – The management response should not include unattainable goals. It should take into account the current resources available to them and proportionate to the recommendation. **Relevant** – The action should take into account the Health Board's goals, vision and IMTP objectives. **Time based** – Each management response must include a date when they believe the recommendation will be implemented by and influenced by the priority of the recommendation raised. This date should be realistic and consider current resources available.
Who signs off each management response?	Audit and Assurance engages with many staff during each audit. However, each audit has a responsible Executive. The Executive responsible for each audit / recommendation must be the person to sign off / agree the management response.
Is the Director the responsible person for each recommendation?	Although the Executive must confirm that they are satisfied with each of the management responses, they do not need to be the responsible person for the actions required. It is often the case that they are not the most appropriate person to implement recommendations and / or supporting actions. When noting the responsible person, the title of the job position only should be included, as the individual responsible may change roles.

How long does management have to provide a management response?	Under our Audit Charter, which is agreed upon by the Audit, Risk and Assurance Committee, we ask for management responses to be provided within 15 working days. However, within 10 working days is a typical response time, except in the case of the most complex of audit reports provided. We do measure the management response time as part of our KPIs, which are supplied to the Health Board on a quarterly basis. Often the management response is closely aligned to the recommendation(s) raised and is a relatively simple matter to provide.
Do all audit recommendations require a completion date from management?	Yes. This is to ensure the Health Board can easily track every recommendation and follow up on those that are overdue. This also enables the Audit, Risk and Assurance Committee to receive assurance over the management and implementation of management actions and / or to be aware of any additional risk arising. The date of completion of the management actions must be specific, for example, December 2022 or February 2023. The following are unhelpful responses for target dates: 1. 2022 – Just noting the year in which the action will be completed is not specific enough. 2. TBC – A date must be given for each recommendation. If this is not possible then management should consider amending their management response to ensure it is specific enough for a time deadline to be included. 3. Ongoing – This again is not specific. If the recommendation is ongoing, management should note the deadline as the month when they believe it will have been fully implemented or to set out the accomplishment of the actions in stages.
Deadline extension	The deadline for management to have implemented each recommendation should not be extended unless there is a satisfactory reason for delay. Justification for this should be presented to the Audit, Risk and Assurance Committee.
Recommendation closure	Recommendations will be closed when sufficient evidence has been presented to the Corporate Governance Team, as custodians of the Audit Recommendation Tracker (the 'Tracker'). This is to ensure that all recommendations have been closed appropriately. The current version of the Tracker is presented to each Audit, Risk and Assurance Committee. Ensuring the management response is SMART is imperative as evidence of completion will be required before the Health Board will close the recommendation.