Audit, Risk & Assurance Committee

Tue 16 April 2024, 13:30 - 16:00

Agenda

1. Preliminary Matters

1 Audit Risk and Assurance Committee Agenda 16.04.241.pdf (3 pages)

1.1. Welcome

Oral *Chair*

1.2. Apologies for Absence

Oral *Chair*

1.3. Declarations of Interest

Oral *Chair*

1.4. Draft Minutes of the last meeting held on 8th February 2024

Attached *Chair*

1.4 08_02_2024 Draft Audit Risk and Assurance Minutes. Chair Approved.pdf (11 pages)

1.5. Committee Action Log

Attached *Chair*

1.5 08_02_2024 Audit Risk Assurance Committee Action Log Chair Approved.pdf (5 pages)

2. Items for Discussion

2.1. To Receive the External Audit Progress Report

Attached *Performance Audit Lead, Audit Wales*

To include a verbal update on Stakeholder Survey

2.1 Audit Risk and Assurance Committee Update - April 2024.pdf (10 pages)

2.2. To Review the Primary Care Follow-up Report following amendments

Attached *Performance Audit Lead, Audit Wales*

2.2 3564A2023_abuhb_primary_care_follow-up_final.pdf (25 pages)

2.3. To Receive the Internal Audit Progress Report

Attached *Head of Internal Audit*

2.3 ABUHB April 2024 Audit Committee Progress Report.pdf (8 pages)

2.4. To Receive Internal Audit Reports

2.4.1. Unified Breast Unit at Ysbyty Ystrad Fawr - Substantial Assurance

Attached *Head of Internal Audit*

2.4.1 SSU ABU 2324 03 YYF Unified Breast Care Final Audit Report.pdf (19 pages)

2.4.2. Asset Management - Reasonable Assurance

Attached *Head of Internal Audit*

2.4.2 ABUHB 2324-4a Asset Mangement Final Internal Audit Report.pdf (13 pages)

2.4.3. Risk Management - Reasonable Assurance

Attached *Head of Internal Audit*

2.4.3 Final Risk Management internal audit report.pdf (8 pages)

2.4.4. Long-Term Sickness Absence Management - Reasonable Assurance

Attached *Head of Internal Audit*

2.4.4 AB-2324-20 LT Sickness Management Final Report.pdf (12 pages)

2.4.5. Follow-up of High Priority Recommendations - Not Rated

Attached *Head of Internal Audit*

2.4.5 ABUHB 2023.24 Follow-Up Final Internal Audit Report.pdf (6 pages)

2.5. To Receive an early indication on the Head of Internal Audit's Final Opinion Report

Oral *Head of Internal Audit*

2.6. To Receive and Endorse the Internal Audit Annual Workplan 2024/25

Attached *Head of Internal Audit*

2.6 ABUHB_2024-25_DRAFT Internal Audit Plan v1.3.pdf (30 pages)

2.7. To Receive the Strategic Risk and Assurance Report

Attached *Director of Corporate Governance*

2.7 Committee Risk Report_ARAC_April 2024.pdf (6 pages)
2.7a Appendix A Strategic Risk Register.pdf (8 pages)
2.7b Appendix B Strategic Risk Dashboard and Risk Assessments.pdf (33 pages)

3. Items for Approval/Ratification/Decision

3.1. To Approve the Audit, Risk and Assurance Committee Work Plan 2024/25

Attached *Director of Corporate Governance*

3.1 Cover Paper Audit Risk and Assurance Committee Work Plan 2024_25.pdf (4 pages)
3.1a Appendix 1_DRAFT ARA_Committee Work Programme 2024-25 v2.pdf (6 pages)

3.2. To Approve the Audit, Risk and Assurance Annual Report 2023-24

Attached *Director of Corporate Governance*

3.2 Cover Report Audit Risk and Assurance Committee Annual Report 2023-24.pdf (4 pages)
3.2 Appendix 1_DRAFT Audit_Risk and Assurance Annual Report 2023_24. v2docx.pdf (41 pages)

3.3. To Approve the closing position of the Internal/External Audit Recommendations Tracker for Q4 2023/24

Attached *Director of Corporate Governance*

3.3 Internal_External Audit Recommendations Q4 23_ 24 Cover Report ARAC.pdf (7 pages)

- 3.3a Appendix 1 - Dashboard.pdf (1 pages)
- 3.3b Appendix 2 - Pre 2022 Overdue Recommendations Pre Q4 Update.pdf (5 pages)
- 3.3c Appendix 3 - Post 2022 Overdue Recommendations Pre Q4 Update.pdf (17 pages)
- 3.3d Appendix 4 - Revised Timescale Requests following Q4 Updates.pdf (14 pages)
- 3.3e Appendix 5 - Overdue Recommendations Following Q4 Updates.pdf (1 pages)
- 3.3f Appendix 6 - Completed Recommendations Following Q4 Updates.pdf (10 pages)
- 3.3g Appendix 7 - Not Yet Due.pdf (8 pages)

3.4. To Approve the Report on the Use of Single Tender Action

Attached *Director of Finance and Procurement*

To include; A briefing note on the due diligence process for the Community Transport Association's Single Tender Action.

- 3.4 Single Tender Action Report -20.01.2024 - 22.03.2024.pdf (3 pages)
- 3.4a Appendix A - Single Tender Action 20.01.2023 - 22.03.2024 (1).pdf (5 pages)

3.5. To Receive the Report on Financial Governance and Reporting; and, Ratify Financial Control Procedures (FCPs)

Attached *Director of Finance and Procurement*

- Accounts Receivable
- Counter Fraud Communication Strategy
- Contract Management

- 3.5 Governance Report 16.04.2024.pdf (10 pages)
- 3.5a Appendix 1 ABUHB_Finance_0239 Accounts Receivable Final.pdf (27 pages)
- 3.5b Appendix 2 ABUHB_Finance_0581 Counter Fraud Communication Strategy Final.pdf (11 pages)
- 3.5c Appendix 3 ABUHB_Finance_0996 Contract Management Final.pdf (7 pages)

4. Items For Information

4.1. No Items Received

5. Other Matters

5.1. Items to be Brought to the Attention of the Board and Other Committees

Oral *Chair*

5.2. Any Other Urgent Business

Oral *Chair*

5.3. Date of the Next Meeting

- Tuesday 21st May 2024 (Draft Accounts)

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DIT, RISK & ASSURANCE COMMITTEE AGENDA	
e and Time	**sday 16th April at 13:30pm**
ue	**rosoft Teams**

Item	Title	Format	Presenter
1	**PRELIMINARY MATTERS**		
1.1	Welcome and Introductions	Oral	Chair
1.2	Apologies for Absence	Oral	Chair
1.3	Declarations of Interest	Oral	Chair
1.4	Draft Minutes of the last Meeting held on 8th February 2024	Attached	Chair
1.5	Committee Action Log	Attached	Chair
2	**ITEMS FOR DISCUSSION**		
2.1	To Receive the External Audit Progress Report - To include a verbal update on Stakeholder Survey	Attached	Performance Audit Lead, Audit Wales
2.2	To Review the Primary Care Follow-up Report following amendments	Attached	Performance Audit Lead, Audit Wales
2.3	To Receive the Internal Audit Progress Report	Attached	Head of Internal Audit
2.4	To Receive Internal Audit Reports	Attached	Head of Internal Audit
2.4.1	**Substantial** Unified Breast Unit at Ysbyty Ystrad Fawr		
2.4.2	**Reasonable** Asset Management		
2.4.3	**Reasonable** Risk Management & Assurance		

2.4.4	**Reasonable** Long-Term Sickness Absence Management		
2.4.5	**Not Rated** Follow-up of High Priority Recommendations		
2.5	To Receive an early indication on the Head of Internal Audit's Final Opinion Report	Oral	Head of Internal Audit
2.6	To Receive and Endorse the Internal Audit Annual Workplan 2024/25	Attached	
2.7	To Receive the Strategic Risk & Assurance Report	Attached	Director of Corporate Governance
3	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
3.1	To Approve the Audit, Risk & Assurance Committee Work Plan 2024/25	Attached	Director of Corporate Governance
3.2	To Approve the Audit Risk and Assurance Annual Report 2023 - 24	Attached	
3.3	To Approve the Closing Position of the Internal/External Audit Recommendations Tracker for Q4 2023/24	Attached	
3.4	To Approve the Report on the Use of Single Tender Action. To include; • A briefing note on the due diligence process for the Community Transport Association's Single Tender Action.	Attached	Director of Finance and Procurement
3.5	To Receive the Report on Financial Governance and Reporting; and, Ratify Financial Control Procedures (FCPs); • Accounts Receivable • Counter Fraud Communication Strategy • Contract Management	Attached	
4	**ITEMS FOR INFORMATION**		
4.1	No Items Received		

5	OTHER MATTERS		
5.1	Items to be Brought to the Attention of the Board and Other Committees	Oral	Chair
5.2	Any Other Urgent Business	Oral	Chair
5.3	**Date of the Next Meeting**: • Tuesday 21st May 2024 (DraftAccounts)		

Motion to Exclude Members of the Public and the Press
There may be circumstances where it would not be in the public interest to discuss a matter in public. In such cases the Chair shall move the following motion to exclude members of the public and the press from the meeting: "*Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest".* *Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960*

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN/ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

MINUTES OF THE AUDIT, RISK AND ASSURANCE COMMITTEE ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DATE OF MEETING	Thursday 8th February 2024
VENUE	Microsoft Teams

PRESENT	Iwan Jones - Independent Member, Committee Chair Richard Clark– Independent Member, Committee Vice Chair *(left at 10:00)* Shelley Bosson - Independent Member
IN ATTENDANCE	Rani Dash- Director of Corporate Governance Lucy Windsor – Head of Corporate Risk and Assurance Rob Holcombe - Director of Finance and Procurement Nicola Prydgodzicz – Chief Executive, ABUHB *(Left at 09:56 joined 10:30)* Michelle Morris – Head of Counter Fraud *(Left at 10:00)* Stephen Chaney – Deputy Head of Internal Audit Nathan Couch – Audit Wales Mark Ross – Assistant Finance Director Andrew Doughton – Audit Wales Leeanne Lewis – Assistant Director Quality and Patient Safety *(Joined 10:00 left at 10:10)* Sarah Simmonds – Executive Director Workforce and OD *(Joined 11:25 Left 11:35)* Peter Carr – Executive Director of Therapies and Health Science *(Joined 10:35 Left 11:07)* Leanne Watkins – Chief Operating Officer *(Joined 09:53 left at 11:06)* Jamie Marchant – Divisional Director Facilities *(Joined 10:15)* Laura Howells – Auditor, Internal Audit Huw Richards – Auditor, Internal Audit David Butler – Auditor, Internal Audit *(Left 11:00)* Richard Harries – Audit Wales David Murphy – Audit Wales *(Joined 10:35)* Lloyd Hambridge – Divisonal Director Primary Care*(Joined 11:00 Left at 11:25)* Danielle Jackson – Secretariat

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Apologies	

ARAC 0802/1	**Preliminary Matters**
ARAC 0802/1.1	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
ARAC 0802/1.2	**Apologies for Absence** There were no apologies of absence noted
ARAC 0802/1.3	**Declarations of Interest** There were no declarations of interest raised to record.
ARAC 0802/1.4	**Minutes of the previous meeting** The minutes of the meeting held on the 23rd November 2023 were agreed as a true and accurate record.
ARAC 0802/1.5	**Committee Action Log** The Committee reviewed the action log, noting actions completed, actions in progress, and actions that were not yet due.
ARAC 0802/2	**Items for Approval / Ratification/ Decision**
ARAC 0802/2.1	**To Endorse the change to the Risk Appetite Statement** Rani Dash (RD), Director of Corporate Governance, Provided the Committee with a summary of the proposed changes to the Risk Appetite Statement. The committee were informed that the Board approved the Risk Management Framework on the 25 January 2024, it was requested that the Risk Appetite Statement be updated to remove the word "reputation" in relation to the Confidence and Trust theme to avoid misinterpretation. *"The Health Board's natural position is to not tolerate risks that breakdown or impact confidence & trust. However, building on and maintaining the confidence and trust of all stakeholders, including staff is vital, so to highlight both the complexity and importance of transparency, the Health Board shall be cautious to any risk or opportunity that may influence that confidence and/or trust."* The Committee **NOTED** the report and **ENDORSED** the amended description for the risk theme of Confidence and Trust
ARAC 0802/2.2	**To Approve the Report on the use of Single Tender Action** Mark Ross (MR), Assistant Finance Director, provided the Committee with a summary on Single Tender Action Waivers – 11 November 2023 – 19 January 2024. The Single Tender Action (STA) schedule contained a summary of the two STA requests that had been submitted and approved to a total value of £123,262.22.

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	- Community Transport Association - Care-Com Systems Iwan Jones (IJ), Committee Chair, inquired as to whether any due diligence takes place to review how money is spent by contractors. Robert Holcombe (RH), Director of Finance and Procurement confirmed that it would be expected for the management team commissioning the service to monitor the contract terms and organisational arrangements. RH agreed to look further into the due diligence process followed specifically for the Community Transport Association STA and bring provide a short paper back to committee for assurance. **Action: Director of Finance and Procurement.** The Committee **NOTED** the report.
ARAC 0802/2.3	**Ratification of Financial Governance, Reporting and Control Procedures.** Mark Ross (MR), Assistant Finance Director, provided the Committee with a summary of financial governance, reporting and controls. There were two financial control procedures presented that required approval. • Petty Cash • Petty Cash – Mental Health Shelly Bosson (SB), Independent Member, queried the use of petty cash, due to modernisation and the lack of physical cash used in many places. Iwan Jones (IJ), Committee chair, supported this by raising the question of whether Petty Cash is still a requirement. Robert Holcombe (RH), Director of Finance and Procurement advised that petty cash arrangements are being cut down in line with modernisation, however, there is at present a requirement to keep an element of cash due to the general public using cash in certain circumstances; for example, situations in which reimbursements to patients are required instantly meaning cash is the most suitable method. It was noted that the NHS Public sector payment remained in a good position, albeit just below the 95% target; the non-NHS payment remained in a positive position, above 95%. The Committee **APPROVED** both financial control procedures and noted the contents of the report for Assurance.

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ARAC 0802/3	Items for Discussion
ARAC 0802/3.1	**To Receive Counter Fraud Report** Michelle Morris (MM), Head of Counter Fraud, provided the Committee with an overview of the Quarter 3 2023/24 Counter Fraud Report. The Committee was informed that there were three scheduled risk assessments to take place throughout the next quarter; Petty Cash, Omnicell storage of WP10s and Staff Banking. Shelley Bosson (SB), Independent Member, inquired when the ESR Counter Fraud E-Learning training was expected to go live, Michelle Morris (MM) confirmed that a meeting is scheduled to determine a date. SB, inquired why the E-System "Self-Care" is taking such a long time to be introduced. MM, advised that it was due to the volume of data that was required transferring prior to the system being fully implemented. Iwan Jones (IJ), Committee Chair, asked if there was a possibility of displaying numerically how many staff should have completed mandatory training to compare to how many had. MM, agreed to explore what data was available in ESR to inform future reporting. ACTION: Head of Counter Fraud The Committee **NOTED** the contents of the report for assurance.
ARAC 0802/3.2	**To Receive an update on Clinical Audit Activity 2023/24** Leeanne Lewis, Assistant Director Patient Quality and Safety, Provided the Committee with an overview of the 23/24 Clinical Activity report. The Committee was informed that the updated Clinical Audit Plan for 2024/25 and Clinical Activity Report for 2023/24, would be ratified at PQSOC in April 2024. It was noted that a standardised audit report had been developed., The Audit Management and Tracking (AMAT)plan had been fully implemented and AMAT was also being utilised to record all local audits. It was confirmed that full responsibility for Clinical Audit would be transferred to the People, Quality and Safety Committee after April 2024.

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	The Committee **NOTED** the contents of the report.
ARAC 0802/3.3	**To Receive the 2023/24 Committee Programme of Business and update on the development of the 2024/25 Programme of Business.** Rani Dash (RD), Director of Corporate Governance, advised that the 2024/25 Committee Programme of Business was under development. A strengthened process had been implemented to ensure clear alignment to the Committee's Terms of Reference, outcomes of Committee self-assessments and ensure all assurance requirements were considered and included. The Committee **NOTED** the Committee Programme of Business.
ARAC 0802/3.4	**Review Internal and External Audit Recommendations Tracking** Rani Dash (RD), Director of Corporate Governance, provided the Committee with a summary of the Internal and External Audit Recommendation Tracker and requested that the Committee approve the 31 recommendations that had proposed revised timescales, 30 completed, leaving a residual position of 12 overdue recommendations. Peter Carr (PC), Director of Therapies and Health Sciences, Provided the committee with an assurance update on the 2017 Medical Equipment Devices Recommendation as requested at the previous Audit, Risk and Assurance Committee Meeting. An extension to the agreed deadline was requested to allow the recommendation to be fully implemented. Richard Clark (RC), Independent member, left meeting at 10:00am, as this item required approval of the closing position of audit recommendations and the meeting was not quorate, electronic approval was sought and received. The Committee **NOTED** the report and **APPROVED** the 31 revised timescale requests and 30 completed recommendations.
ARAC 0802/3.5	**To Receive Internal Audit Progress Report** Stephen Chaney (SC), Deputy Head of Internal Audit, provided a summary of the Internal Audit Progress Report to the Committee. It was requested to defer the 2023/24 Maternity Action Plan Audit to 2024/25, to enable embedding of updated processes following consolidation of all actions relating to maternity from various internal and external audits. Shelley Bosson (SB), Independent Member, raised concerns surrounding the delay of the Maternity Action Audit due to

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	possible risks which was supported by the Committee Chair. SC acknowledged the possible risks of delaying the audit and recommended that the audit not be deferred. It was noted that the 2024/25 audit plan was in the process of being developed, a number of key areas had been highlighted that require focus. The draft plan would be shared with the Committee at its next meeting. SC requested the views of the Committees in respect of to including a whistleblowing audit in the 2024/25 plan. The Committee supported inclusion of a Whistleblowing Audit The Committee **NOTED** the Report and rejected the request to the amendment to the 2023/24 Internal Audit Plan.
ARAC 0802/3.6	**To Receive Internal Audit Reports** Stephen Chaney (SC) - Deputy Head of Internal Audit, provided the Committee with a summary of the following two limited and two reasonable assurance reports with the support of the Lead Executive and capital audit. - Facilities – Limited Assurance - Estates Condition – Limited Assurance - Data Quality – Reasonable Assurance - IT Stakeholder Engagement – Reasonable Assurance **Facilities** The Committee was informed that the audit was completed at the request of facilities management following two identified areas of concern, the bank process for facilities staff and the management of stock. The main areas of concern highlighted following the audit related to the management of stock process. Iwan Jones (IJ), Committee Chair, requested further detail around the stock review trend, SC confirmed that recommendations highlighted in previous reviews needed to be implemented to identify any trends. A decision to complete a full review at a later date was agreed. IJ, inquired whether enough time had been allocated to complete the recommendations. Jamie Marchant (JM), Divisional Director Facilities, reassured the committee that the team remain committed to complete recommendations within the timescales provided.

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	IJ requested a date to be provided for recommendation Management response to *"8.1 Continue to monitor Bank Shift Booking Reports and address issues in accordance with Health Board policy".* **ACTION: Divisional Director Facilities** **Estates Condition** Huw Richards – Auditor, Internal Audit informed the Committee that the estates condition audit had taken place across all NHS organisations within Wales, following completion an overall summary report would be shared with Health Boards and Welsh Government. Shelley Bosson (SB), Independent Member, raised concerns regarding plans to address issues highlighted considering the significant cost involved. Nicola Prydgodzicz (NP, Chief Executive,confirmed that discretionary funding of £2 million, which was cut had since been reinstated. Work was ongoing to develop clearer future plans and to determine areas of prioritisation. SB inquired about the source of funds for addressing the backlog prior to the handover of PFI buildings. Robert Holcombe (RH), Director of Finance and Procurement, confirmed that the cost would be taken from capital funds. **Data Quality** IJ, queried the extensive timeline agreed to produce and implement a procedure. SC) confirmed that due to volume of data it is likely to be a time extensive process. **IT Stakeholder Engagement** The Committee noted the contents of the audit report. The Committee **NOTED** the audit reports for assurance.
ARAC 0802/3.7	**To Receive External Audit Progress Report 2023/24** Nathan Couch (NC), Audit Wales, provided the Committee with a summary of the External Audit Progress Report. It was reported that the Audit of Accounts 2022/23 and Charitable funds work had been completed and reported to the relevant committees.

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	Richard Harries (RH), Auditor Internal Audit, informed that the deadline of accounts had been brought forward to the 15th July from the 31st July which had been agreed by Welsh Government. It was noted that the 2024/25 timetable plan would be presented to the Committee at its meeting in April 2024. The Committee **NOTED** the Report and change to the audit of accounts schedule.
ARAC 0802/3.8	**To Receive the External Audit Annual Audit Report** Nathan Couch (NC), Audit Wales, Provided the Committee with a summary of the External Audit Annual Report. The Committee was informed that considering the financial challenges across NHS Wales it was decided to focus on financial savings and cost improvement plans, it was anticipated that the report would be finalised in April 2024. The Review of unscheduled care arrangements report was anticipated as being to be completed and published March 2024. The review of Quality Governance and planned care remained in the scoping stage. The Committee **NOTED** the Report.
ARAC 0802/3.9	**To Receive the Audit Wales Primary Care Follow-up Report** Andrew Doughton (AD) Performance Audit Manager, Audit Wales provided the Committee with a summary of the Primary Care Follow-up Report with the support of Lloyd Hambridge (LH), Primary Care Divisional Director. It was noted that the purpose of the audit was a follow up review of the Primary Care Review undertaken in 2019. Robert Holcombe (RH), Director of Finance and Procurement, raised concerns as the financial resource recommendations contained throughout the report he had not been sighted on and stated that there had been no engagement with the finance team. RH requested to revisit the report before being approved by the Committee. **ACTION: Director of Finance and Procurement and Audit Wales.** Iwan Jones (IJ), Committee Chair, requested that following the engagement with Finance and any amendments be bought back to the Committee for oversight **ACTION: Secretariat**

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	Shelley Bosson (SB), Independent Member, asked if there was a plan in place to incorporate a strategic risk relating to Primary Care as recommended within the report. Rani Dash (RD), Director of Corporate Governance reassured the Committee that work was underway to develop a Corporate Risk Register and meetings were scheduled with Executive Directors to identify all corporate risks and ensure all strategic risks were recorded in the Strategic Risk Register. **ACTION: Head of Risk and Assurance** The Committee **NOTED** the Report.
ARAC 0802/3.10	**To Receive the Workforce Planning Report** David Murphy (DM), Audit Wales, Provided the Committee with a summary of the Workforce Planning Report with the support of the Lead Executive. Sarah Simmonds (SS), Director of Workforce and Organisational Development reassured the Committee that work to complete recommendations was ongoing noting that the report and progress update was scheduled for the People and Culture Committee on the 22nd of February. Shelley Bosson (SB), Independent member inquired as to whether the date for recommendation 2 had been determined, SS, confirmed that this had not yet been established and would be presented to the Executive Committee by the end of February 2024. The Committee **NOTED** the Report.
ARAC 0802/3.11	**To Receive the Final Structured Assessment Report 2023** The Committee **NOTED** the Report for information which was received at the Committee's last meeting in November and at the Board meeting in January.
ARAC 0802/3.12	**To Review Standing Orders (SOs), Standing Financial Instructions (SFIs) and Scheme of Delegation (SofD)** Rani Dash (RD), Director of Corporate Governance, presented the Committee with a summary of the Standing Orders (SOs), Standing Financial Instructions (SFIs) and Scheme of delegation report. The Committee was informed that an annual review of SOs, SFIs, and SofDs was required, which was completed and approved by the Board at its meeting in September 2023.

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	Shelly Bosson (SB), Independent Member asked whether DBS checks were a requirement and how they were completed and maintained. RD confirmed that pre-employment checks were conducted by Shared Services. RD agreed to confirm onboarding arrangements and report back to the Committee. **ACTION: Executive Director of Corporate Governance** The Committee **NOTED** the Report and actions required to address areas of non-compliance.
ARAC 0802/3.13	**To Review the adequacy of arrangements for declaring, registering and handling interests** Rani Dash (RD), Director of Corporate Governance, Presented the Committee with an overview of the Declarations of Interest, Register of Gifts and Hospitality Report as at 16th January 2024. The Committee was informed that work was underway to improve and update the policy. The review included discussions with other Health Boards to ensure consistency. The Committee **NOTED** the Report.
ARAC 0802/3.14	**To Receive the Committee Risk and Assurance Report** Rani Dash (RD), Director of Corporate Governance, Presented the Committee with an overview of the Risk and Assurance Report. Shelley Bosson (SB), an Independent Member, questioned the assurance rating process, how it was determined, and whether it determined if risks were being tolerated or managed to an appetite/target level. SB used **SRR 002** - *"There is a risk that there will be a significant failure of the Health Boards Estate, due to significant levels of backlog maintenance and structural impairment"* as an example and was not convinced that the overall assessment rating was consistent with the controls, assurances, and current risk score to determine an overall reasonable assurance rating. RD confirmed that this was new approach to reporting risks that was still being developed and stated that the assurance assessment sought to determine the effectiveness of the controls and what additional measures were required. RD would discuss with the Head of Corporate Risk and Assurance how future reports could demonstrate whether risks were being tolerated or mitigated. The Committee **NOTED** the Report.
ARAC 0802/4	**Items for Information**
ARAC 0802/4.1	**Stakeholder Perception Research Project Report**

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	Richard Harries (RH), Audit Wales, presented the Committee with a summary of the Stakeholder Perception Research Project Report for awareness. Iwan Jones (IJ), Committee Chair, inquired about the action plan in place to ensure the recommendations highlighted were being addressed. RH, agreed to discuss with the chair what was expected and how the Committee would like to see the report for the next meeting. **ACTION: Committee Chair and Audit Wales** The Committee **NOTED** the Report.
ARAC 2811/5	**Other Matters**
ARAC 2811/5.1	**Items to be Brought to the Attention of the Board and Other Committees** It was noted that a more comprehensive overview of the audit recommendation position would be provided to the board within the summary report.
ARAC 2811/5.2	**Any Other Urgent Business** No items for any other business.
ARAC 2811/5.3	**Date of the next meeting;** • Tuesday 16th April 2024 at 13:30

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CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
Audit Risk and Assurance ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
July 2023	**ARAC1807/2.1** Clinical Audit Update	A completed Ward Assurance Audit to be included within the activity update scheduled for the Committee meeting in February 2024 for information.	Medical Director	08 February 2024	**In Progress** 06.01.2024 – The implementation of Ward assurance audits is still in its early stages, and one has not been completed in its entirety, so there is no data to demonstrate outcomes at this time.
November 2023	**ARAC 2811/3.1** Losses and Payments Report	Circulate a briefing note to Committee Members detailing the Losses and Special Payments made by the Health Board.	Director of Finance and Procurement	21 May 2024	**Not Yet Due.**

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
ACTION LOG

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
November 2023	**ARAC 2811/3.4** Job Planning Arrangements	Following full implementation of the job planning process an update report is to be received at a future meeting to provide assurance that all audit recommendations have been implemented.	Medical Director Secretariat	Schedule for Q1/Q2 2024/25.	**Not Yet Due.**
November 2023	**ARAC 2811/3.9** Review of Audit Recommendations Tracking	Review outstanding overdue audit recommendations with respective executive directors during one-to-one meetings.	Chief Executive Officer	08 February 2024	**Completed.**
January 2024	**ABUHB 2401/16** Risk Management Framework	Rewording of "Reputational Risk" to be amended and presented at the Audit, Risk and Assurance Committee.	Head of Risk and Assurance	March 2024	**Completed.**
February 2024	**ARAC 0802/2.2** To Approve the use of Single Tender Action	Produce a briefing note to the Committee detailing the due diligence process followed in relation to the Community Transport Association Single Tender Action.	Director of Finance and Procurement	16 April 2024	**Completed** Briefing%20for%20the%20Audit%20Comm

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
ACTION LOG

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
February 2024	**ARAC 0802/3.1** To receive Counter Fraud Report	Explore data available via ESR in relation to staff mandatory training.	Head of Counter Fraud	16th April 2024	**In Progress.** As a result of the item being deferred, this information will be included in the report scheduled for May.
February 2024	**ARAC 0802/3.6** To receive Internal Audit Reports	Provide a completion date for recommendation 8.1 Internal Audit Facilities Report.	Divisional Director of Facilities	February 2024	**Completed**
February 2024	**ARAC 0802/3.9** To Receive the Audit Wales Primary Care Follow-up Report	ABUHB finance department and Audit Wales to revisit the Primary Care Follow-up Report and update Management Responses.	Director of Finance and Procurement and Audit Wales	16 April 2024	**Completed**
February 2024	**ARAC 0802/3.9** To Receive the Audit Wales Primary Care Follow-up Report	Primary Care Follow-up Report to be brought back to Audit Committee following amendments.	Secretariat	16 April 2024	**Completed**

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
ACTION LOG

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
February 2024	**ARAC 0802/3.9** To Receive the Audit Wales Primary Care Follow-up Report	Meet with Executive Directors to identify all corporate risks and develop a comprehensive Corporate Risk Register.	Head of Risk and Assurance	March 2024	**In Progress** 14/03/2024 - The HofCRA has conducted initial meetings with Executive Directors to discuss their risks. Risk assessments are underway and will be reviewed over the course of the next 4 weeks and will be presented to the Board meeting in May 2024 as part of the Strategic Risk Report.
February 2024	**ARAC 0802/3.12** To Review Standing Orders, Standing Financial Instructions and Scheme of delegation.	Circulate a briefing note to Committee Members detailing the on boarding process of Shared Services	Director of Corporate Governance	16 April 2024	**Completed** PDF Copy of Final Non Executive Directors F

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
ACTION LOG

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
February 2024	**ARAC 0802/4.1** Stakeholder Perception Research Project Report	Liaise to discuss how the committee would like to receive the report on the action plan for implementation of recommendations.	Committee Chair and Audit Wales	16 April 2024	**Completed** Audit Wales to provide a verbal update to the committee 16th April 2024.

All actions in this log are currently active and are either part of the Committee's forward work programme or require more immediate attention, such as an update on the action or confirmation that the item scheduled for the next Committee meeting will be ready.

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

Archwilio Cymru
Audit Wales

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

Date issued: April 2024

Document reference: 3997A2024

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.

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About this document

1 This document provides the Audit, Risk and Assurance Committee with an update on our current and planned accounts and performance audit work at Aneurin Bevan University Health Board.

2 We also provide additional information on:

- Other relevant examinations and studies published by the Audit General.
- Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.

3 Details of future and past Good Practice Exchange (GPX) events are available on our website.

Accounts audit update

4 Exhibit 1 summarises the status of our current and planned accounts audit work.

Exhibit 1 – Accounts audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Audit of Accounts 2023-24	Rob Holcombe – Director of Finance and Procurement	We will follow the audit approach designed as part of our planning work and undertake appropriate audit testing to enable to Auditor General to provide his opinions on the financial statements of the Health Board.	Planning	Audit of Accounts report presented to the July 2024 Audit, Risk and Assurance Committee
Audit of Charitable Fund Accounts 2023-24	Rob Holcombe – Director of Finance and Procurement	We will follow the audit approach designed as part of our planning work and undertake appropriate audit testing to enable to Auditor General to provide his opinion on the financial statements of the Charitable Fund.	Not started	To be confirmed

Performance audit update

5 Exhibit 2 summarises the status of our current and planned performance audit work.

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment 2023 – Deep dive	Nicola Prygodzics – Chief Executive Officer	In addition to the core structured assessment work, we will also undertake "deeper dive" work in a specific area. We had initially identified digital transformation as the deeper dive topic for 2023. However, given the financial challenges facing the NHS at present, we are looking to now focus our deep dive work in health boards on financial savings / cost improvement plans.	Planning	To be confirmed
Follow-Up of Primary Care Services	Leanne Watkins – Chief Operating Officer	Follow-up of recommendations made in our Primary Care services review	Report amended and updated report in today's committee papers	April 2024

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Unscheduled Care Arrangements	Leanne Watkins – Chief Operating Officer	This work has been carried forward from the 2020 Audit Plan, after having initially been postponed due to the pandemic. Our phase one work has examined discharge planning arrangements and patient flow. We will assess the Health Board's progress against the 2017 audit recommendations we made on discharge planning. We are also producing a report for the Health Board and its partners on the Regional Partnership Board that describes progress being made in developing whole system solutions to delayed discharges.	Reporting	To be confirmed
Quality Governance Review Follow up	Jennifer Winslade – Executive Director of Nursing James Calvert – Medical Director Peter Carr – Executive Director of Therapies and Health Sciences	The work will assess the extent to which previous audit recommendations arising from our thematic review of Quality Governance arrangements have been implemented and are delivering the intended outcomes / benefits. It will also focus on the Health Board's preparedness for the Duty of Quality and Candour and the effectiveness of its governance arrangements in providing assurance over its compliance.	Project Brief Issued	To be confirmed

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Tackling NHS Waiting Lists	Leanne Watkins – Chief Operating Officer	This work will be completed across all health boards and follows on from our national overview report on the planned care backlog in May 2022. Although we are still in the scoping phase, we intend to consider waiting list performance and arrangements to improve elective waits.	Planning	To be confirmed

Other relevant publications

6 Exhibit 3 provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update.

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

Title	Publication Date
Supporting Ukrainians in Wales	**March 2024**
From firefighting to future-proofing – the challenge for Welsh public services	**February 2024**
Corporate Joint Committees – commentary on their progress	November 2023

Additional information

7 Audit Wales is currently developing its Annual Plan for 2024-25 and this will be circulated when available.

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

Archwilio Cymru
Audit Wales

Primary Care Follow-up Review – Aneurin Bevan University Health Board

Audit year: 2022

Date issued: December 2023

Document reference: 3654A2023

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

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and Audit Wales are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

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

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

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Summary report

Introduction

1 Primary care is the first point of contact for most people who use health services in Wales. It encompasses a wide range of services, delivered in the community by a range of providers, including General Practitioners (GPs), Pharmacists, Dentists, Optometrists, as well as other professionals from the health, social care, and voluntary sectors.

2 In 2018-19, the Auditor General reviewed primary care across all Health Boards in Wales, with a particular focus on general practice. That work focussed on strategic planning, investment, workforce, oversight and leadership, and performance.

3 Our 2019 Review of Primary Care at Aneurin Bevan University Health Board (the Health Board) found that it had comprehensive plans for primary and community care and was making steady progress towards implementing the key elements of the national vision. While performance levels were above average for many indicators, growing workforce pressures were challenging the sustainability of core GP services in some areas. The Health Board had assessed the workforce challenges in some practices and was in the early stages of testing solutions. Primary care plans were informed by Neighbourhood Care Network plans, but the networks were not fully mature. Despite strong leadership arrangements, limited performance indicators did not allow oversight of all areas of primary care and there was scope for greater focus on primary care at Board-level. Our 2019 work also found examples of resources shifting closer to home and the aim was to increase investment in primary care. However, our report recommended that more needed to be done to form a baseline of the investment and resource use.

4 The landscape for primary care in Wales has changed since our original review in 2019:

- Welsh Government has published its long-term plan for health and social care - A Healthier Wales. The plan highlights primary care's crucial role in helping to realise the ambition of creating a seamless whole system approach with services designed around people, based on their needs, supporting them to stay well and not just providing treatment when they become ill. This means that more services traditionally provided in a hospital setting are shifted into the community to provide care at home or closer to home to take pressure off hospitals and reduce the time people wait to be treated.
- the Strategic Programme for Primary Care is the all-Wales primary care response and contribution to 'A Healthier Wales'. It set out six workstreams:
  - focussing on 'ill-health' prevention and wellbeing;
  - developing 24/7 access to services;
  - exploiting data and digital technologies;
  - strengthening workforce and organisational development;

  - improving communications and engagement; and
  - developing ‘cluster-level’ vision and enabling service transformation.
- in February 2023, the National Primary Care Board, which oversees the Strategic Programme for Primary Care, identified that work is progressing at a varying pace within each Health Board area. Aligned to this, there are wider concerns around the capacity of central Primary Care Services Teams within Health Boards to deliver organisational priorities, as well as Board-level visibility and focus on primary care.
- Welsh Government has embarked on an ambitious programme of contract reform across General Medical Services, Dentistry, Community Pharmacy, and Optometry to:
  - ensure primary care services are sustainable;
  - improve patient access to primary care services;
  - reinforce the focus on quality and prevention;
  - enable cluster working to plan and deliver services; and
  - strengthening the workforce.
- primary care services were severely impacted by the COVID-19 pandemic. Whilst the immediate public health emergency has subsided, primary care providers continue to face challenges as they recover and reconfigure their services with the aim of responding to the needs and expectations of the public in a post-pandemic world.

5 Our review has focussed primarily on assessing the extent to which the Health Board has implemented our 2019 recommendations. However, we have also undertaken some additional work to consider the extent that:

- the Health Board’s central Primary Care Services Team has the appropriate capacity and capability (in terms of knowledge, skills, and experience) to deliver local and national priorities, as well as to manage day-to-day operational and business needs; and
- the Board and / or its committees regularly consider matters relating to the planning, performance, risks, and opportunities associated with the Health Board’s primary care services.

6 The methods we used to deliver our work are summarised in **Appendix 1**.

Key findings

7 Overall, we found that **the Health Board has made reasonable progress in addressing our previous recommendations, particularly in relation to public engagement and Neighbourhood Care Network development and activity. However, the sustainability of some primary care services remains a concern and there needs to be a more co-ordinated, unified, and strategic approach to primary care planning, resourcing, and reporting on outcomes.**

Implementation of previous audit recommendations

8 We found that **the Health Board has strengthened public engagement and key aspects of Neighbourhood Care Network activity and development. It is also beginning to improve its approach to evaluating new ways of working, which will ultimately need to inform whether Primary care mainstream these initiatives.**

9 The Health Board has strengthened key aspects of Neighbourhood Care Network activity and development. Whilst there remains some variation in Neighbourhood Care Network membership, representation at meetings has improved and there are clear plans to develop arrangements further. The Health Board has clearly defined the role of the Neighbourhood Care Networks as part of the Primary Care and Community Services Division, the five Integrated Service Partnership Boards, and the Public Service Boards. The Health Board continues to invest in leadership development, and all Neighbourhood Care Networks Leads have completed the Confident Primary Care Leaders course. However, there is no specific locum Neighbourhood Care Network Lead post to provide additional capacity and backfill for absences and share learning.

10 The Health Board is strengthening its approach to public engagement, and this is helping both to highlight pressures facing the primary care system and signpost alternative services as they become embedded. But the Health Board needs to become better at determining the extent that its investment in primary care improvement is delivering the intended impact. There also isn't a truly evaluative approach to determine the impact Neighbourhood Care Network initiatives, although the Health Board is strengthening its evaluation approaches during 2023. Where there is evidence of evaluation, the Health Board does not always allocate mainstream funding to new ways of working. This could mean that impactful approaches to manage health conditions in the community may not be embedded.

Board-level visibility and focus on primary care

11 We found that **primary care is appropriately reflected in Health Board strategies and plans. However, there is a need for a more integrated, unified, and strategic approach to primary care planning and resource utilisation. Whilst primary care reporting to the Board and its committees has improved,**

opportunities remain to provide greater coverage on primary care challenges, opportunities, improvements, and risks.

12 Primary care services are appropriately reflected in the Health Board's clinical futures strategic plans, Integrated Medium-Term Plan (IMTP), and 11 underpinning Neighbourhood Care Networks IMTPs. Between them, they set out a high-level ambition and some detailed improvement actions to transform services. The Health Board has a Primary Care and Community Services Integrated Medium Term Plan for the 2023-26 period. This incorporates both service modernisation and the sustainability of primary care services and integrates enabling requirements including digital, estates, communications, workforce and quality. The Health Board is intending to move away from a solely community service focussed plan, from 2024, to integrate primary and community services with acute services aligned to wider clinical futures strategy and plans.

13 There is improving primary care reporting to the Board and committees, but it is fragmented which makes is hard to form a collective view on the primary care challenges, opportunities, improvements, and risks. There remain a very limited number of corporately reported performance indicators for primary care. There needs to be clearer outcome-based measures and reporting to help to understand what impact or difference is being achieved.

Capacity and capability to deliver local and national priorities

14 We found that **the work of primary care support and contracting teams has broadened and increased significantly. But it has also become increasingly crisis-driven, and this needs to be addressed as a priority**.

15 The work of primary care support and contracting teams has grown significantly; however, they are increasingly crisis-driven. The Health Board recognises a need to review the function of the Primary Care Operational Support Team to provide 'upstream support' rather than crisis response and consider team resourcing levels. At present though, resources supporting transformation are separate to core primary care practice support which may mean that overall capacity is not best utilised.

Recommendations

Implementation of previous audit recommendations

16 Based on our findings above and in the detail of this report, the status of our 2019 audit recommendations is summarised in **Exhibit 1**. We have provided the progress and status against each recommendation in more detail in **Appendix 2**.

17 The Health Board has provided an update to the open recommendations, setting out proposed action for improvement (**Appendix 3**).

Exhibit 1: status of our 2019 recommendations

Implemented	Ongoing	No action	Superseded	Total
7	8	0	1	16

Detailed report

Implementation of previous audit recommendations

18 We considered the Health Board's progress in implementing our 2019 audit recommendations. These focus on:

- investment in primary care (2019 Recommendations 1a and b);
- new ways of working (2019 Recommendations 4a, b, c, and d); and
- Neighbourhood Care Networks (2019 Recommendations 5a, b, c, d, and e).

19 Recommendations relating to oversight of primary care at Board and committees (2019 Recommendation 2 and 2019 Recommendations 3a, b, and c) are discussed later in this report.

20 Overall, we found that **the Health Board has strengthened public engagement and key aspects of Neighbourhood Care Network activity and development. It is also beginning to improve its approach to evaluating new ways of working which will inform future investment decisions.**

Investment in primary care

21 We considered whether the Health Board has:

- calculated a baseline position for its current investment and resource use in primary and community care (2019 Recommendation 1a); and
- reviewed and reported, at least annually, its investment in primary and community care to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care (2019 Recommendation 1b).

22 We found **that the Health Board is reporting on its baseline and changing profile of investment between hospital and non-hospital services.**

23 The Health Board has analysed and routinely reported on the comparative trends between acute and community services. It implemented a different approach to budget setting for the 2023-24 financial year based on forecast spend within divisions rather than based on historical budgets. This is intended to address the historical issue of funding not being transferred between divisions and is to be accompanied by greater focus on baselines to help facilitate activity and resource shift in the future. **We therefore consider Recommendation 1a to be completed**. 'A Healthier Wales' clearly seeks a shift in resources to community services, there are a range of examples, more recently community based MSK services, but also minor skin surgery and ophthalmology/optometry integration which show increasing shift towards community and primary care based services. The Health Board have analysed the initiatives and changes in 'out of hospital care' by division. **We therefore consider Recommendation 1b to be complete**.

New ways of working

24 We considered whether the Health Board has:

- worked with the Neighbourhood Care Networks (NCNs) to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes, and to inform decisions on whether to expand these models (2019 Recommendation 4a);
- centrally collated evaluations of new ways of working and shared the learning by publicising the key messages across all NCNs (2019 Recommendation 4b);
- begun to fund these new models from mainstream funding, subject to positive evaluation, rather than from the Primary Care Development Fund (2019 Recommendation 4c); and
- worked with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce demand for GP appointments (2019 Recommendation 4d).

25 We found that the Health Board **has appropriately strengthened its arrangements for promoting new ways of working amongst the public and signposting them to alternative points of contact. However, given growing funding constraints, it needs to become better at systematically evaluating the outcomes from new models and initiatives to inform decisions on continued investment**.

26 The Health Board started its new Neighbourhood Care Network[1] funded project evaluation process in January 2023. Its aim is to assess projects systematically and objectively to improve accountability, measurement, and increased transparency of project outcomes. The work is being led by Neighbourhood Care Network Office Service Improvement Managers who are providing support to locality teams. Through these new approaches, the Health Board is expecting to strengthen its evidence base for projects, inform decision making, help to identify key organisational learning, and establish unmet need and demand. The Health Board is planning to prepare evaluation outcomes in time to inform the 2024-25 Neighbourhood Care Network Plan development process. The Primary Care and Community Services Division performance dashboard is also under review, and the Health Board currently plans to update this to reflect the agreed measurement strategy across the Neighbourhood Care Network funded projects. **We therefore consider Recommendations 4a and 4b to be ongoing**.

[1] A Neighbourhood Care Network (also known as a GP cluster) is a 'place-based' partnership network whose aim is to shape services at a neighbourhood level (typically supporting populations of 40,000 to 60,000). The Health Board has 11 Neighbourhood Care Networks in total.

27 There are some examples where new models and initiatives have become mainstream in primary care. These include the Ophthalmology Diagnostic Treatment Centre for Glaucoma and Wet AMD (age-related macular degeneration), the extended Minor Skin Surgery Service, and the introduction of an Integrated Primary and Community Care Academy. However, the Health Board faces risks when implementing new primary care services as many sources of funding are non-recurrent. If the funding stops, this could either affect the sustainability of new models and initiatives or result in unfunded service cost pressures within the Primary Care and Community Services Division. The Health Board's central Neighbourhood Care Network Office is working with the Value-Based[2] Health Care Team to evaluate new models that are clearly demonstrating impact. This will then be used to support business case proposals to begin mainstreaming some models of care that are proven to be effective. The Neighbourhood Care Network Office is also strengthening financial governance to ensure there is an Award Letter and Project Initiation Document or Service Level Agreement in place for all Neighbourhood Care Network funded projects. These agreements will specify the outcome data to be collected to inform decisions about scaling-up and mainstreaming effective models. **We therefore consider Recommendation 4c to be ongoing**.

28 The Health Board appointed a Communication and Engagement Officer in October 2022 to help ensure that the public are aware of pressures and alternative services which can help to reduce the pressure on GPs. This has resulted in stronger and more coordinated communication programme that is aligned to the wider corporate Health Board approach. Furthermore, the Health Board is appropriately promoting several alternative points of contact including the:

- Community Pharmacy Common Ailment Service;
- Eye Health Examination Wales Service;
- Urgent Dental Hotline; and
- NHS 111 Option 2 for Mental Health Crisis support.

29 In support of the new arrangements above, the Health Board requires that all existing patient-facing staff undertake the national care navigation training package as part of the national GMS Contract access commitment. All new patient-facing staff complete the national care navigation training package within three months of their start date. The Health Board has recently produced and shared videos on its social media channels featuring Neighbourhood Care Network Leads as part of a wider social media campaigns to help manage patient expectations during periods of peak demand. Part of that work included the production of video stories to raise public awareness of extended roles within primary care such as associate nurse practitioners, clinical pharmacists, and psychological health practitioners. **We therefore consider Recommendation 4d as implemented**.

[2] Value-based healthcare is the equitable, sustainable, and transparent use of available resources to achieve better outcomes and experiences.

Neighbourhood Care Networks

30 We considered whether the Health Board has:

- reviewed the relative maturity of clusters, and targeted and strengthened its support for clusters where necessary (2019 Recommendation 5a);
- reviewed the membership of NCNs and attendance at NCN meetings to assess whether there is a need to increase representation from local authorities, third sector, lay representatives and other stakeholder groups (2019 Recommendation 5b);
- clarified and publicised governance and leadership arrangements for NCNs, to ensure better understanding of the responsibilities for decision making (2019 Recommendation 5c);
- ensured that all NCN leads have attended the Confident Primary Care Leaders Course (2019 Recommendation 5d); and
- considered introducing a locum NCN lead post, to work across all NCNs providing additional capacity and backfill for leads. The post could also be valuable in sharing learning across NCNs (2019 Recommendation 5e).

31 We found that **the Health Board has made good progress in implementing new Neighbourhood Care Networks and wider governance structures, as well as supporting individuals to develop their leadership skills**.

32 Internal Audit's report on Neighbourhood Care Networks, issued in December 2022, concluded that they were not fully mature, drawing attention to complex primary care structures. Since then, Welsh Government has set 2022-23 as a transition year for introducing new local authority footprint-based partnership governance structures and has awarded £0.56 million of additional funding to the Health Board to support their development[3]. Throughout 2022-23, the Health Board has utilised the funds to create an Accelerated Cluster Development Hub project to strengthen governance structures, and to support pan-cluster planning and local Neighbourhood Care Network delivery and distributed leadership. The Strategic Programme for Primary Care Fund is also supporting additional capacity and capability to:

- enhance health intelligence,
- promote service improvement, communication, and engagement,
- and strengthen workforce planning, organisational development, and business support across the networks.

The Accelerated Cluster Development Hub Project and associated programme has made good progress in supporting the Neighbourhood Care Networks and creating the local authority footprint-based (pan-cluster) Integrated Services Partnership Boards. **We therefore consider Recommendation 5a as implemented**.

[3] Aneurin Bevan University Health Board Strategic Programme for Primary Care year 1 funding proposals

33 Neighbourhood Care Network governance is guided by nationally agreed Terms of Reference for NHS Wales Clusters. This sets out the responsibility of individual cluster members and the role of the Health Board in leadership. The membership and structure of the Health Board's Neighbourhood Care Networks have developed over the last year, resulting in strengthened representation from local authorities and the third sector in all Neighbourhood Care Networks. Furthermore, the 'Professional Collaboratives' are also starting to provide a mechanism for GP Practices, Dental Practices, Community Pharmacies, Optometry Practices, Community Nurses, and Allied Health Professionals to together. Over time, these collaboratives should support development within their profession specific groups and facilitate working across a Neighbourhood Care Network to design solutions that meet the needs of local people. **We therefore consider Recommendation 5a as implemented**.

34 The Health Board agreed its Neighbourhood Care Networks governance and leadership arrangements at its public Board meeting on 30 November 2022. This set out the structure, roles, interrelationships between the Accelerated Cluster Development Programme Board, the Supporting Neighbourhood Care Networks Office, and local government and health board corporate leadership structures and scrutiny committees. The Board also agreed the partnership governance structure for planning and delivery under the Regional Partnership Board, which included the 5 Integrated Services Partnership Boards, the role of the Neighbourhood Care Networks, and the underpinning role of professional collaboratives. During the first three months of 2023-24, the Health Board has published its first newsletter "Neighbourhood Care Network News", which signposts to progress of the work of the networks and provides links to updated website information on the form and function of the networks. **We therefore consider Recommendation 5c as implemented**.

35 The Health Board is investing in corporate support for individuals to develop their leadership skills. All Neighbourhood Care Networks Leads have completed the confident primary care leaders course. In addition, neighbourhood care network leads are encouraged to pursue other leadership development opportunities. This includes, for example, the Health Education and Improvement Wales leadership training platform and also pairing some leads with those in other health boards. The newly appointed workforce transformation manager has developed a bespoke leadership development programme for Neighbourhood Care Networks and Professional Collaborative lead roles. **We therefore consider Recommendation 5d as implemented**.

36 There is no specific 'locum' Neighbourhood Care Network Lead post to provide additional capacity and backfill for absences and share learning as we previously recommended. However, the Health Board's investment in its Accelerated Cluster Development Hub, including its supporting development programme, is improving the resilience of delivery arrangements. **We therefore consider recommendation 5e as superseded**.

Board-level oversight of primary care

37 We considered the extent to which the Board and / or its committees regularly consider matters relating to the planning, performance, risks, and opportunities associated with the Health Board's primary care services. In doing so, we specifically considered whether the Health Board has:

- reflected primary care in its strategies and plans in line with the ambitions of 'A Healthier Wales';
- developed an action plan for raising the profile of primary care in the Health Board (2019 Recommendation 2); and
- ensured the contents of Board and committee performance reports adequately cover primary care (2019 Recommendations 3a, b, and c).

38 We found that **primary care is appropriately reflected in Health Board strategies and plans. However, there is a need for a more centralised, unified, and strategic approach to primary care planning and resource utilisation. Whilst primary care reporting to the Board and its committees has improved, opportunities remain to provide greater coverage of primary care challenges, opportunities, improvements, and risks**.

39 Welsh Government is encouraging localised planning at a cluster level and strengthening co-ordination at a local authority footprint level through the creation of pan-Cluster Planning Groups, known as Integrated Services Partnership Boards. The Health Board's primary care improvements are developed 'bottom up' by the Health Board's Neighbourhood Care Networks. All Neighbourhood Care Networks have developed their own Integrated Medium-Term Plans for the period 2020-23. Some have also recently prepared Annual Plans for 2023-24. The two published 2023-24 Neighbourhood Care Network 'cluster plans' link appropriately to national strategy, policy, and legislation. They also both effectively align to the priorities of the Health Board and relevant local authorities. The Health Board's Integrated Medium-Term Plan provides a reasonable approach for consolidating some quite detailed short-term primary care actions to be delivered during 2023-24.

40 However, the many plans that cover primary care services do not sufficiently allow the Health Board to collectively understand the totality of its resource requirements. Whilst the Neighbourhood Care Network Plans appropriately identify delivery actions, they do not effectively identify the totality of the resource requirements needed to deliver them. This is particularly notable in terms of digital, workforce, capital, and estate resource requirements.

41 The regional and place-based Neighbourhood Care Network planning is supported by national and often short-term funding streams. The Health Board is utilising national Strategic Programme for Primary Care Funds to support area-based planning and enhance obesity services.

42 Furthermore, whilst the Health Board's IMTP identifies primary care improvements, it is difficult to see the totality of the capital and revenue resource required to deliver the plans. As a result, we cannot determine whether there is sufficient

resource allocated to deliver the Health Board's primary care aims and ambition. Nor can we determine whether the Health Board is planning to utilise the totality of its current £276 million primary care and community revenue spend to best effect.

43 The Health Board has a Primary Care and Community Services Integrated Medium Term Plan from 2023-26. This incorporates both service modernisation and the sustainability of primary care services and integrates enabling requirements including digital, estates, communications, workforce and quality. The Health Board is intending to move away from a solely community service focussed plan, from 2024, to integrate primary and community services with acute services aligned to wider clinical futures strategy and plans. This should assist the Health Board in developing new integrate care pathways.

44 Our review of Board papers over the year to August 2023 found that whilst the Health Board is increasing and improving Board and committee oversight of primary care services, it remains very fragmented:

- core primary care divisional spend against budget is included in the finance update to Finance and Performance Committee and the Board. However, this doesn't give a sense of whether primary care services are financially efficient.
- information on the funding of wider Neighbourhood Care Network improvement work is not routinely reported. The report on Accelerated Cluster Development (Neighbourhood Care Network development) programme report prepared for the July 2023 Partnerships, Population Health, and Planning Committee, provided a good overview on actions and improvement activity but little information on costs or quantified outcomes.
- Primary Care Sustainability updates to the Board (including Board briefings) and the Partnerships, Population Health and Planning Committee over the last year frequently refer to failing practices, practice closures and managed practices. This helps the Board react to increased primary care risk, but because it is not reported alongside wider cluster improvement plans it makes it difficult to see a joined-up sustainable solutions.
- Board IMTP updates include frequent references to primary care although these are on a relatively narrow range of primary care issues/initiatives.
- the Board Assurance Framework (BAF) does not identify any risks regarding the achievement of strategic aims for primary care. For example, it does not include:
  - a strategic risk relating to the Health Board's ability to achieve a shift in resources to primary care to fulfil the goals set out in 'A Healthier Wales'.
  - a strategic risk relating to corporate primary care resources to support transformation and change.
- the Integrated Performance Report contains some primary care indicators, but these do not effectively reflect either the primary care sustainability risks or

wider Neighbourhood Community Network plans. Furthermore, they do not focus on outcomes, the impact achieved from improvement initiatives, or measures that may help to indicate primary care service sustainability risk.

- the 2021-22 Annual Report on Primary Care provides a good overview of developments and risks across general medical services, general dental services, general ophthalmic services, and community pharmacy services. However, there is limited information on finances, performance reporting, and links to wider Neighbourhood Care Network activities. Evidence suggests that the annual report did not go to a committee or the Board, and we have not seen any evidence to indicate that a 2022-23 Annual Report in primary care services has been prepared and reported to committee or the Board.

45 As a result of the above, Board members are unable to form a strategic view on the totality of the primary care services and whether actions will lead to sustainability of services in the longer term. **We therefore consider Recommendation 2 and Recommendations 3a, b, and c to be ongoing**.

Capacity and capability to deliver local and national priorities

46 We considered whether the Health Board's central Primary Care Services Team has the appropriate capacity and capability (in terms of knowledge, skills, and experience) to deliver local and national priorities, as well as to manage day-to-day operational and business needs. In doing so, we considered whether the central Primary Care Services Team has:

- an appropriately resourced structure, which is kept under review, with clear lines of accountability; and
- arrangements for identifying and supporting learning and development needs, and succession planning on an ongoing basis.

47 We found **the work of primary care support and contracting teams has broadened and increased significantly. It has also become increasingly crisis-driven, and this needs to be addressed as a priority.**

48 The Primary Care Operational Support Team (the Support Team) was established to provide support for GP practices working closely with the Urgent Primary Care Team (UPTC). The Support Team resides in the Chief Operating Officer's portfolio and comprises three nurses, one pharmacist and two administrators. It supports GP practices in several areas, including:

- recruitment challenges;
- early practice interventions;
- assisting managed practices;

- the Merger Incentive Scheme[4]; and
- addressing vacant practice outcomes.

49 Several practices have required crisis support in recent years, which has limited the capacity of the Support Team to work on the prevention agenda and support early interventions. The Primary Care Contracting Team was originally developed as a back-office function to manage primary care contracts. It too has become increasingly involved in managing the Health Board's response to contract resignations and branch surgery closures. This includes responding to the resultant patient and service provider concerns and helping to support multi-disciplinary team-based solutions for primary care.

50 Because of increasing concerns about the sustainability of some primary care services, the Health Board re-established the Primary Care Sustainability Board in October 2022. Its remit is to oversee and direct a programme of work to improve the sustainability of primary care services. This includes a strong focus on training, staff retention, and a public communications strategy. The Primary and Community Care Academy was also re-established in 2023. Its remit includes workforce planning and succession planning, identifying training needs and developing an education and training programme, workforce development, communications, and engagement with primary care providers.

51 The Health Board recognises the need to review the function of the Support Team to provide 'upstream support' rather than crisis response and to consider team resourcing levels. Alongside the capacity to support the day-to-day operation of services, the Health Board is also investing in strengthening its support for Neighbourhood Care Network development. The Neighbourhood Care Network office, coordinated by a Senior Programme Manager includes a Commissioning Manager, leads for organisational development, communications and engagement, a business management, and data analysis capacity. The office also includes, dental, optometry and pharmacy clinical advisory capacity. Neighbourhood Care Network Office capacity is supported by funding from the Strategic Programme for Primary Care and supports Neighbourhood Care Network development and related clinical service design.

52 At present and as identified above, resources supporting primary care transformation are separate to core primary care practice support which may mean that overall capacity is not being used to full effect. In reviewing the function and resource levels of the Support Team, the Primary Care Sustainability Board should consider opportunities to bring operational and transformational resources together in a more integrated way to strengthen resilience and optimise resources.

[4] The Health Board introduced the Merger Incentive Scheme in 2018 in order to support practices with smaller population list sizes to reach the necessary critical mass required to deliver the most effective and sustainable services.

Appendix 1

Audit methods

Exhibit 3 sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

Exhibit 3: audit methods

Element of audit methods	Description
Documents	We reviewed a range of documents, including: • Neighbourhood Care Network's plans from 2020 onwards. • Health Board Integrated Medium Term Plans. • Cluster Annual Plans. • Relevant primary care focussed Board and Committee papers. • Papers relating to the April 2023 Board Development Session. • Patient Quality Safety and Outcomes Committee agenda and papers. • Relevant Internal Audit Reports including reports on NCNs, and Tredegar and Newport Health and Wellbeing Centres. • Self-Assessment. • Collaborative leadership development resources. • Organisational/divisional structures. • Relevant Executive team briefings.
Interviews	We interviewed the following: • Executive Director of Primary Care (prior to restructure). • Assistant Director of Primary Care. • Consultant in Public Health. • Lead Independent Member for Primary Care. • Head of Primary Care. • Deputy Medical Director.
Observations	We observed the Board Development session focussing on primary care in April 2023.

Appendix 2

A summary of progress against our 2019 recommendations

Exhibit 4 sets out the recommendations we made in 2019 together with our summary assessment of progress in 2023.

Exhibit 4: our recommendations from 2019

Recommendation	Progress
Recommendation R1a Calculate a baseline position for its current investment and resource use in primary and community care.	**Implemented** – See paragraph 23
Recommendation R1b Review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care.	**Implemented** – See paragraph 23
Recommendation 2 The Health Board should develop an action plan for raising the profile of primary care in the Health Board. Actions could include ensuring a standing item on Board agendas regarding primary care and publishing an annual report on primary care.	**Ongoing** – See paragraphs 43 to 49
Recommendation 3a Review the contents of its Board and committee performance reports to ensure sufficient attention is paid to primary care.	**Ongoing** – See paragraphs 43 to 49
Recommendation 3a Review the contents of its Board and committee performance reports to ensure sufficient attention is paid to primary care.	**Ongoing** – See paragraphs 43 to 49
Recommendation 3b Review the frequency with which Board and committees receive performance reports regarding primary care.	**Ongoing** – See paragraphs 43 to 49

Recommendation	Progress
Recommendation 3c Review the way it currently reports to Board and committees on its progress in delivering its plans for primary care, and importantly, how it is reporting on improved outcomes for patients in primary care.	**Ongoing** – See paragraphs 43 to 49
Recommendation 4a Work with the NCNs to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models.	**Ongoing** – See paragraph 30
Recommendation 4b Centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all NCNs.	**Ongoing** – See paragraph 30
Recommendation 4c Subject to positive evaluation, begin to fund these new models from mainstream funding, rather than from the Primary Care Development Fund.	**Ongoing** – See paragraph 31
Recommendation 4d Work with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce demand for GP appointments.	**Implemented** – See paragraph 32
Recommendation 5a Review the relative maturity of NCNs, to develop and implement a plan to strengthen its support where necessary.	**Implemented** – See paragraph 36
Recommendation 5b Review the membership of NCNs and attendance at NCN meetings to assess whether there is a need to increase representation from local authorities, third sector, lay representatives and other stakeholder groups.	**Implemented** – See paragraph 36

Recommendation	Progress
Recommendation 5c Clarify and publicise the governance and leadership arrangements for NCNs, to ensure better understanding of the responsibilities for decision-making.	**Implemented** – See paragraph 37
Recommendation 5d Ensure all NCN leads attend the Confident Primary Care Leaders course.	**Implemented** – See paragraph 38
Recommendation 5e Consider introducing a locum NCN lead post, to work across all NCNs providing additional capacity and backfill for leads. The post could also be valuable in sharing learning across NCNs.	**Superseded** – See paragraph 39

Appendix 3

Organisational response to audit recommendations

Exhibit 5 below sets out the Health Board's response to our audit recommendations.

Recommendation	Organisational response	Completion date	Responsible officer
Recommendation 2 The Health Board should develop an action plan for raising the profile of primary care in the Health Board. Actions could include ensuring a standing item on Board agendas regarding primary care and publishing an annual report on primary care.	The Health Board's Integrated Medium-Term Plan is based on the life course approach and consequently includes key priorities for primary care to integrate across the whole health care system. Monitoring of the Primary Care related elements of the IMTP follow the same format as other areas, including Executive chaired monthly assurance meetings, mid-year reviews, end of year reviews and issue led discussion at Executive Team, Health Board and other committees. The Division has been invited to lead a number of Board development sessions over the past 12 months, notably the presentation of the Primary Care Sustainability plan, which includes the expansion of the primary care academy and is key in ensuring the workforce of the future. The weekly Executive Team meeting provides a forum to discuss any issues across the operational divisions, and primary care features regularly on the agenda. This will include updates from the primary care contracting team reporting on GP and other independent contractor changes. A potential risk that Primary Care could lose profile at Board level due to re-structure and cessation of the Executive Director for Primary Care post. However, stability has been brought to the Primary Care & Community Services Division through substantive appointment of a new Divisional Director with presence at senior committees within the Health Board. Welsh Government no longer requires the Health Board to submit an annual plan for primary care, however a report is produced for internal purposes.	**Actions complete and will continue ongoing**	**Director of Corporate Governance/ Divisional Director Primary and Community**

Recommendation	Organisational response	Completion date	Responsible officer
Recommendation 3 a) Review the contents of its Board and committee performance reports to ensure sufficient attention is paid to primary care. b) Review the frequency with which Board and committees receive performance reports regarding primary care. c) Review the way it currently reports to Board and committees on its progress in delivering its plans for primary care, and importantly, how it is reporting on improved outcomes for patients in primary care.	As with the other operational Divisions, Primary Care forms part of the Health Boards regular agendas across the various Committees and Boards. The Divisions performance is reported as part of the overarching reporting against the IMTP and is presented to each formal Board meeting and the Finance and Performance Committee. The Primary Care Division will be updating the Health Board at the April Development session to report on progress against the sustainability workstream. There is work ongoing to integrate the Divisions data into the Performance Report for the Finance & Performance Committee. Initially this will be a minimum data set with plans to expand reporting in the future. Ad hoc / topic specific reports are requested and shared with the Executive Team / Board on a regular basis.	**Action complete and will continue ongoing** **April 2024** **December 2024**	**Director of Corporate Governance/ Divisional Director Primary and Community**

Recommendation	Organisational response	Completion date	Responsible officer
Recommendation 4a a) Work with the NCNs to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models. b) Centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all NCNs. c) Subject to positive evaluation, begin to fund these new models from mainstream funding, rather than from the Primary Care Development Fund.	NCN project evaluation framework has been established. There have been some successes in terms of substantiating services previously funded by NCNs to release funding back into new initiatives. This includes conversion of many practice-based pharmacists to practice-employed status and cessation of funding of direct-access physiotherapy / first contact physiotherapists with the advent of the MSK Hub. Plans being put in place to utilise *Building Capacity through Community Care: Further Faster* funding to scale up other successful projects, such as care home in-reach. Some other initiatives requiring resolution, including future funding of Psychological Wellbeing Practitioners. Significant work has been undertaken to understand the implications of an alternative skill mix model for primary care. Costed workforce plans are being developed with support from Corporate Workforce Team – funded via Strategic Programme for Primary Care. Workforce modelling has indicated the scale of the problem with insufficient training being commissioned by HEIW. The Health Board has subsequently agreed to invest funding – as a cost pressure – into an expanded Primary Care & Community Academy, in agreement that a sustainable future funding model is a priority.	**Actions complete and will continue ongoing**	**Director of Primary & Community Services**

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

Internal Audit Progress Report

Audit, Risk and Assurance Committee

April 2024

Aneurin Bevan University Health Board

NWSSP Audit and Assurance Services

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1. Introduction

The purpose of this report is to:

- confirm the status of the audit work for the 2023/24 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board') to the April 2024 Audit, Risk and Assurance Committee (the 'Committee');
- discuss and seek approval for the draft 2024/25 Internal Audit Plan; and
- provide an overview of other activity undertaken since the previous meeting.

2. Progress against the 2023/24 Internal Audit Plan

There are 29 individual reviews in the 2023/24 Internal Audit Plan and an additional review included regarding Facilities. In addition, our Specialist Services Unit (SSU) undertake assurance work over major capital projects.

The table below details progress against the 2023/24 Internal Audit Plan.

Number of audits in plan:	29
Additional review: Facilities	1
Less: deferred audits	(3)
Revised total	27
Number of audits reported as final	13
Number of audits reported as draft	6
Number of audits work in progress	7
Number of audits at planning stage	1

The following 2023/24 final reports have been issued since the meeting of the Audit, Risk and Assurance Committee on 8th February 2024:

AUDIT ASSIGNMENT	**ASSURANCE RATING**
Unified Breast Unit at Ysbyty Ystrad Fawr	Substantial
Long Term Sickness Absence Management	Reasonable
Asset Management	Reasonable
Risk Management	Reasonable
Follow-up of High Priority Recommendations	Not rated

The delivery status of the audits is illustrated within Appendix A and further information over the assurance rating detailed above is included within Appendix B.

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 reports issued since the last meeting on 8th February 2024.

Unified Breast Unit at Ysbyty Ystrad Fawr (substantial assurance)

The audit sought to review the management arrangements in place to progress the Ysbyty Ystrad Fawr Unified Breast Unit – in the period after the prior audit, which was completed in December 2022.

Following Welsh Government approval and commencement on site, the contract completion date has only been extended by two weeks – noting the audit was completed eight weeks prior to anticipated completion. The project was forecast to be delivered £200k under the approved budget, resulting in a small gain share for the Health Board and Supply Chain Partner.

Generally, the audit observed sound controls and good compliance across the assurance objectives. The key recommendations raised include:

- Whilst not having a significant impact on the key objectives of this project, minutes should be sufficiently robust to record discussions, decisions, and actions.
- All Project Progress Reports submitted to the Welsh Government should routinely be fully completed and comprehensive. Recognising that the project is highly likely to be delivered within acceptable tolerances for time and cost, substantial assurance has been determined at this stage of the project's development.

Long Term Sickness Absence Management (reasonable assurance)

We undertook a review over a sample of areas to determine compliance with the NHS Wales Managing Absence at Work Policy. This was not an audit on the number of sickness absence episodes, but whether the Health Board is acting promptly and managing the interests of all parties within the process of managing long term sickness absence.

We selected a sample throughout the Health Board, to encompass a mixture of teams (clinical and office based) and different sites. Overall, within our sample testing we largely found that the policy is being applied correctly, alongside additional actions to aid staff in implementing the policy. These actions include training, sickness absence groups and deep dives to assist with the design of action plans.

We also found pockets of good practice, which would assist the wellbeing of staff. The processes within Facilities were of a high quality, with the Service Improvement Team playing a significant role. We raised a couple of recommendations to assist the Health Board, including reviewing the NHS Wales Managing Attendance at work Policy: Information Pack and to focus training and support within areas where compliance is not as strong.

Asset Management (reasonable assurance)

This review provided an opinion over the effectiveness of the Health Board's processes to create and maintain accurate and up-to-date records of its equipment assets. In particular, we focused on the roll-out of RFID tagging.

Overall, we noted that the asset register relies on manual processes for data capture and updating. This uses both paper flows from asset owners advising of additions, disposals and asset movements and capital spend analysis to update the equipment asset register. However, we found delays in the receipt of these change forms, leading to register inaccuracy.

The radio frequency (RFID) asset tagging process, which has now reached 67% of the eligible equipment base, with a plan to complete the process by March 2025, improves asset management and, in particular, facilitates asset physical verification. However, as with the manual process, we found weaknesses persist around equipment disposal management.

Risk Management (reasonable assurance)

This review sought to assess the effectiveness of the risk management and assurance arrangements in place within the Health Board, to ensure that strategic objectives are achieved. We focussed on the management of risks within the Digital Services Directorate.

Overall, we found a clear escalation process is in place enabling risks to be effectively reviewed at an appropriate level. We also found that risks are being appropriately scored and updated with actions and updates regularly provided.

We raised a recommendation relating to the following matters arising:

- Risks should be migrated to Datix when the necessary Datix upgrades are made.
- An overarching Directorate risk register should be compiled. There should be a clear and documented process of review of the risk register. This can be achieved when risks are migrated to Datix.

Follow-up of High Priority Recommendations (not rated)

This review assessed whether a sample (23 in total) of high priority recommendations were appropriately included on the Audit Recommendation Tracker (the 'Tracker'). Where the recommendations sampled had been implemented and subsequently removed from the Tracker, we assessed whether this was appropriate to do so.

Overall, as with previous reviews of this area, we found that recommendations were being tracked appropriately. We also found that for our sample of recommendations tested that they had been removed appropriately. However, we raised a management point for further consideration, including whether the implementation timeframe for some outstanding recommendations still remained appropriate.

4. 2024/25 Internal Audit Plan

The 2024/25 Draft Internal Audit Plan (the 'Plan') has been produced and is reported to the April Committee meeting for review, discussion and approval. The process for the development of the Plan is the same as for previous years.

The draft Plan reflects the general risk profile of the organisation, as shown in the Strategic Risk Register and rotational coverage of key areas. The Plan may require revision, both in terms of coverage and timing when it is appropriate to do so. If required, this will be done through the established governance and approval processes.

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 workforce procedures; and
- liaison with senior management.

6. Recommendation

The Audit, Risk and Assurance Committee is invited to **note** the above points within the report and to **review** and **approve** the draft 2024/25 Internal Audit Plan.

Appendix A: Progress against 2023/24 Internal Audit Plan

Audits	Status
Savings Programmes	WIP
Financial Controls	WIP
Decarbonisation	Draft report
Asset Management	Final report
Medical Equipment & Devices	Draft report
Risk Management & Assurance	Final report
Follow-up of High Priority Recommendations	Final report
The Health & Social Care (Quality & Engagement) (Wales) Act	Deferred
Integrated Medium Term Plan	Final report
Integrated Performance Dashboard - Data Quality	Final report
Business Continuity Planning	Final report
Safeguarding	Final report
Waiting List Management	WIP / Draft report
Directorate Review - Theatres	WIP
Job Planning	Deferred
Clinical Coding	Final report
Providing Care to Asylum Seekers & Refugees	Planning
Early Supported Discharge - Stroke	Draft report
Intra-site Patient Transfers	Draft report
Regional Partnership Board	Draft report
Long Term Sickness Absence Management	Final report
Maternity (Action Plan)	WIP
Flexible Working (advisory)	WIP
Allegations against Staff Policy	Deferred
Network Infrastructure (VPN)	Final report
Stakeholder Engagement on IT Projects	Final report
LINC Programme	Draft report
Bevan Health & Wellbeing Centre	WIP
Estates Assurance - Estate Condition	Final report
Facilities Bank Approval Process	Final report

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.

Unified Breast Unit at Ysbyty Ystrad Fawr

Final Internal Audit Report

December 2023

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

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Auditors:	NWSSP Audit & Assurance: Specialist Services Unit
Executive sign-off:	Leanne Watkins: Director of Operations, Senior Responsible Officer
Distribution:	Andrew Walker: Strategic Capital and Estates Programme Director Hannah Capel: Associate Director of Capital Projects Kelly Jones: Head of Capital Finance
Committee:	Audit Committee

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

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

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

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

Executive Summary

Purpose

The audit sought to review the management arrangements in place to progress the Ysbyty Ystrad Fawr Unified Breast Unit – in the period after the prior audit which was completed in December 2022.

Overview

Following Welsh Government approval and commencement on site, the contract completion date has only been extended by 2 weeks – noting the audit was completed 8 weeks prior to anticipated completion.

The project was forecast to be delivered £200k under the approved budget, resulting in a small gain share for the UHB and Supply Chain Partner (which has not been accounted for within the above).

Generally, the audit observed sound controls and good compliance across the assurance objectives. Key matters requiring management attention include the following:

- Whilst not having a significant impact on the key objectives of this project, minutes should be sufficiently robust to record discussions, decisions, and actions.
- All Project Progress Reports submitted to Welsh Government should routinely be fully completed and comprehensive.

Recognising that the project is highly likely to be delivered within acceptable tolerances for time and cost, **substantial** assurance has been determined at this stage of the project's development.

Report Classification

	Trend
Substantial Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.	2022/2023

Assurance summary [1]

Assurance objectives		Assurance
1	Project Performance	Substantial
2	Validation of Management Actions	Substantial
3	Governance	Reasonable
4	Cost Control & Management	Substantial
5	Change Management	Reasonable
6	Commissioning & Handover	Substantial

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

Key Matters Arising

		Assurance Objective	Control Design or Operation	Recommendation Priority
1.1	Minutes will be sufficiently detailed to record discussions, decisions, and actions.	*3*	Operation	Medium
2.1	PPR reports are missing key field completion such as Programme Manager reporting and cost reports.	*3*	Operation	Medium
4.1	Change control documents should be signed/ authorised using a recognised document control programme.	*5*	Operation	Medium

1. Introduction

1.1 This audit sought to review the progress made in completing agreed management actions from the previous audit, and re-assessed management arrangements in place to progress the Ysbyty Ystrad Fawr (YYF) Unified Breast Unit. The previous audit issued in December 2022 determined a reasonable assurance rating.

1.2 The audit was delivered in accordance with the agreed 2023/24 audit plan for the project, provided within the Full Business Case (FBC).

1.3 Approval was initially provided by Welsh Government on 24 February 2022 to provide a unified facility for high quality diagnostic and treatment services for Breast Care within the University Health Board (UHB). Welsh Government approval of capital funding of £12.239m was received in November 2022, recognising an uplift in costs to take account of current market conditions, revised procurement strategy etc. A further adjustment for inflationary forecast underspend including VAT movement against Welsh Government approval of -£0.255m reduces this figure to £11.984m.

1.4 The audit was undertaken at a point approximately 8 weeks ahead of expected construction completion and commencement of handover and commissioning.

1.5 The potential risks considered within the review were as follows:

- Failure to address previously identified control weaknesses.
- Potential failure to achieve key project objectives (e.g., delivery to time, cost, and quality).
- Failure to achieve key project objectives through poor governance and project management controls.
- Project costs may escalate uncontrollably through an absence of adequate cost control, monitoring, and reporting.
- Value for money may not be achieved through appropriate application of contract control mechanisms.
- Critical success factors may not be achieved.

2. Detailed Audit Findings

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

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

2.2 When assessing progress against the original delivery objectives, this audit notes that:

Time

2.3 Despite the initial delay to commencement of the project from October 2021 to November 2022, it is recognised that revised handover and commissioning has only been extended by 2 weeks.

Cost

2.4 The project forecast was summarised as follows:

Funding	***£m***	***£m***
Initial funding (approved Feb 2022)	*11.623*	
Additional Funding (approved Nov 2022)	*0.766*	
Adjusted for Charitable Funding (see 2.5)	*(0.150)*	
Adjusted for inflationary forecast underspend	*(0.255)*	
Total		***11.984***
Anticipated Costs	***£m***	***£m***
Works Costs	*8.313*	
Change control	*0.034*	
Fees	*0.430*	
Non-works	*0.230*	
Equipment	*0.273*	
Contingency	*0.098*	
VAT	*1.770*	
Subtotal	***11.149***	
Pre-stage 4 Design Fees	*0.638*	
Total		***11.786***
Expected Overspend/ (Underspend)		***(0.198)***

2.5 The project benefited from charitable funding contributions with £150k formally allocated of the total £267k raised to date – the remaining funds have been reserved for enhancements to the interior design. These were initially included in the non-works costs budget incorrectly: the Welsh Government were notified, and a corresponding reduction to the funding was made, as shown above.

Quality

2.6 Noting the current stage of the project, it remains set to deliver the objectives of the business case i.e., the provision of a unified facility for high quality diagnostic and treatment services for Breast Care within the University Health Board (UHB); acknowledging the potential for further enhancements to the facilities utilising the charitable funds available.

2.7 Additionally, future planning considerations for handover have seen proactive Project Board discussions between consultants and project managers relating, amongst other considerations, to the implications of moving Phillips scanners and the potential for taking advantage of the situation to improve the equipment at the new unit.

2.8 Progress made since funding approval in November 2022 results in project performance being assessed as providing a **substantial assurance** level of assurance

2.9 The following sections of the report further outline the key observations in relation to the wider context of project performance discussed above:

Validation of Management Action: An assessment of progress against the agreed management actions from the prior audit report.

2.10 The status of previously agreed management actions from the prior audit report (issued December 2022) can be summarised as follows:

Original Priority Rating	Number of Recommendations	Implemented	Partially Implemented/ Ongoing	Outstanding
High	0	0	0	0
Medium	6	6	0	0
Low	4	4	0	0
Total	**10**	**10**	**0**	**0**

2.11 Noting good progress to address previously agreed recommendations **substantial assurance** has been determined.

Governance: Assurance that appropriate governance arrangements were in place for the current project phase including operation of effective reporting, accountability lines and appropriate approval processes.

2.12 Project governance was defined via a Project Execution Plan (PEP) which included the project objectives, structures, and was supported by terms of reference for both a Project Board and Project Team (in accordance with best practice).

2.13 The PEP had been re-issued since the previous audit to reflect changes implemented to reflect previously agreed management actions; augmenting the information contained within sections of the PEP relating to roles and responsibilities allocated at the project.

2.14 The project governance framework included:

- Project Board – chaired by the Senior Responsible Officer.
- Project Team – chaired by the internal Project Manager (Associate Director of Capital Projects).
- Strategic Capital & Workstream- attended by UHB senior management (including the Director of Planning & Performance), with key issues and project progress included as part of the Capital Project's update report.
- Design Team – responsible for the review of ongoing aspects of the design detail.
- Operational Group – receiving aspects on workforce, pathways, operational flow, and equipment.

2.15 The Project Board met regularly through the construction stage, with well attended meetings. In instances when officers were unable to attend (where apologies were

provided), attendance by a person of equivalent seniority and experience was evidenced. Attendance levels ensured meetings were quorate.

2.16 Conversely, minutes of the Project Board meetings were minimal. Whilst some records of discussion were observed, with some content relating to future planning, the discussions relating to the risk register, change controls, and issues impacting the scheme was not evidenced in detail. The minutes often only noted that key documents were "reviewed with no issues", without recording discussions, decisions, and actions. Whilst not adversely impacting the key objectives of this project, robust minutes would be expected at a project of this size/ value. **MA1**.

2.17 The November 2022 funding approval letter stated a condition to:

"*Provide monthly Project Progress Reports to Welsh Government Official, where necessary by 5pm on the 12th business day bi-monthly*."

2.18 The Project Progress Reports (PPR) reports were produced but were often not routinely completed in the following fields:

- Explanation of resource utilisation by quarter
- Benefits section summary: Benefits realisation plan
- Latest Programme Manager Highlight Report
- Latest cost report.

2.19 It was noted that the Project Bank Account – Section 18 field was only completed when the trust deed had been signed (then included from the July 2023 report); It is considered that reporting by exception is not appropriate in the case of requests for "update on progress", and that this did not adequately reflect the difficulties and delay which were experienced in setting up of the bank account to that date. MA2.

2.20 Despite the above, there was a clear understanding amongst project members on the progress, performance, and key issues arising at the project. Noting also that these issues did not impact negatively on the outturn position, **reasonable assurance** has been determined in relation to governance arrangements applied for the period reviewed.

Cost Control and Management: Assurance that appropriate cost control arrangements were maintained through to the completion of the scheme, including appropriate risk and contingency management, application of pain/gain requirements (as appropriate) and the formulation for an appropriate final account.

2.21 The target cost was scrutinised and approved by the UHB Project Board at the submission of both the FBC and the subsequent increased funding requests. The UHB's cost adviser assessed the market testing of the packages to ensure value for money in reaching the increased sums.

2.22 The cost adviser produced regular costs reports, with consistent formatting which aligns with the UHB's 'Capital Monitoring Forum Project Expenditure Report' and the supporting 'Level 2' supporting detail report in all material ways.

2.23 A recommendation made at the previous audit was to isolate and remove fundraising from intra-report categorisation, in line with the advisory notice to the Welsh Government (also a previous audit report action) that fundraising had been included in initial funding request schedules erroneously.

2.24 Whilst a corrective notice was issued to the Welsh Government and the fundraising value was individually identified on the main cost report, there is a small risk that the absence of a 'subtotal' when presenting the pre-fundraised position, could lead to some misinterpretation on the level of underspend shown at the report. **MA3.**

2.25 During the audit the figures included in the cost reporting and the assertions relating to inflationary calculations were reviewed in detail. These were found to include notation and commentary and the calculations used were easy to follow and ratify.

2.26 The translation of this information to the final published PDF, however, in some areas has been limited, and where additional information may enable users of the report to challenge and scrutinise, some spends such as for 'Equipment' are limited in detail to its class.

2.27 It was evident that users of the report are likely to be familiar with industry wide grouping terminology such as 'Group 3' equipment, however it would be prudent to include the breakdown of the cost to an item basis where large equipment was contributing to a significant financial variance from FBC costings (for example, the September 2023 report showed an adverse variance of £146k: "Group 3 figure includes Ultrasound Equipment £25.5k; and Faxitron costs £106k" would be more appropriate than simply "Group 3"). **MA3**.

2.28 The further review of the nature of transactions demonstrated a prudence in reporting and presentation; it was reported at the time of the audit that there was a potential gainshare situation; due to falling inflation rates, however this had not been acknowledged due to the proximity of the completion of Stage 4 to Christmas 2023, and the consequential impact of any further delays in handover materialising i.e. negating the gain position.

2.29 **Substantial assurance** has therefore been determined in relation to cost control and management, noting only minor enhancements are proposed to current reporting arrangements.

Change Management: To ensure there were appropriate controls and reporting of any project changes, including the potential time and cost impact.

2.30 The change management protocol was adequately detailed within the PEP. Appropriate delegated limits were set for the Project Director (£50k) and the Associate Project Director (£25k). Approvals were recorded using Project Control Forms (PCFs), in addition to the Project Manager Instruction (PMI). Approvals were evidenced in accordance with the scheme of delegation.

2.31 The Project Manager's signature was inserted electronically at all PMIs. However, this was not via a version-controlled document management system such as Adobe sign or Docusign etc. Accordingly, it was not possible to verify the integrity of the signature or when it was dated (2 of the sample were also undated). The Project

Director initially requested an electronic signing programme to be used but was advised that this could not be facilitated externally. It is recognised that in each instance a final approval was sought from the Project Director or Associate Project Director in the form of an email for all PCFs by the Project Managers, nevertheless the use of a recognised document signature software would improve internal control arrangements. **MA4**.

2.32 A sample of 24 Project Management Instructions (PMIs) were inspected at the current audit. Two PMI's were created significantly later than they were actioned. It is recognised that the first example is an omission and the latter a zero financial impact change of specification which had received prominent exposure and review. It would still expect project changes to be administered in a timely manner. **MA4**.

2.33 Initial Change Request Forms were noted to lack information regarding expected impact and, despite clear descriptions linking them to PMI's, PCF's and the Change Control Register, the 'Change Log Number' field had not been populated. **MA4**.

2.34 Recognising the approval processes and evident challenge of changes within emailed correspondence, **reasonable assurance** has been determined in relation to change control arrangements applied at the project.

Commissioning and Handover: Assurance that an appropriate commissioning programme and schedule of activities have been applied in accordance with both contractual and UHB requirements.

2.35 At the date of fieldwork, 8 weeks prior to expected construction completion and commencement of commissioning and handover, there was evidence of several months of liaison with the clinical and service areas at a Project Board level and at progress meetings. There was evidence of assessment of key impact areas and risks associated with commissioning, which had identified movement of mammography equipment as a key issue; and mitigating steps had been taken to progress equipment transfer.

2.36 A detailed programme including factors such as staff handover, training and communication, equipment movement and installation, and procurement and delivery of administrative area furniture had all been included with expected dates of commencement and demonstrating critical delivery paths.

2.37 Recognising the consideration that has been made to date regarding the handover and commissioning, a **substantial assurance** is determined in relation to this objective.

Appendix A: Management Action Plan

Matter Arising 1: Meeting Minutes (Operation)	**Impact**
Good minute taking is essential for effective organisational communication and governance. Accurate minutes serve as a detailed record of discussions, decisions, and actions during meetings, ensuring transparency and accountability. They provide a historical reference, aid in tracking action items, and contribute to organisational memory. In legal contexts, well-crafted minutes can serve as evidence of due process and compliance. Overall, good minute taking is a key element in facilitating informed decision-making and maintaining organisational integrity. Minutes for the Project Board meetings were minimal and whilst some records of discussion were noted, the discussion relating to the risk register, change controls, and issues was not detailed, often only noted as "reviewed with no issues". There was limited record of discussion, challenge, scrutiny or decision making. It is recognised that this has not had an impact on the achievement of the objectives in this instance, however this would be considered basic requirement of all future projects.	A record is not maintained of key discussion, challenge or decision making.

Recommendations		**Priority**
1.1	Minutes will be sufficiently detailed to record discussions, decisions, and actions.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	Accepted. Will ensure this is undertaken for relevant project meetings and is carried forward onto other capital projects.	30th November 2023	Associate Director of Capital Projects

Matter Arising 2: Funding Approval Conditions Not Discharged (Operation)	**Impact**
The funding approval letter of November 2022 stated conditions which included: *"Provide monthly Project Progress Reports to Welsh Government Official, where necessary by 5pm on the 12th business day bi-monthly."* Whilst the Project Progress Reports (PPRs) were provided to the Welsh Government, key fields were not completed in every instance, e.g.: • Explanation of resource utilisation by quarter • Benefits section summary: Benefits realisation plan • Latest Programme Manager Highlight Report; and • Latest cost report It was also noted that the Project Bank Account field (Section 18) was only completed when the trust deed had been signed. It is felt that reporting by exception is not appropriate in the case of requests for "update on progress", and that this did not adequately reflect the difficulties which were experienced in setting up of the bank account to that date.	Potential risk that: • Funding and costs are not appropriately reported.

Recommendations		**Priority**
2.1	Welsh Government Project Progress Reports should be fully populated at each return.	**Medium**
2.2	Progress reporting within the PPR should reflect the current status/ progress, rather than only reporting when a target has been achieved.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Accepted. Will ensure detail is included in the next return and for future Capital Projects	30th November 2023	Associate Director of Capital Projects
2.2	Accepted. Will ensure detail is included in the next return and for future Capital Projects	30th November 2023	Associate Director of Capital Projects

Matter Arising 3: Clarity of Cost Reporting (Operation)	**Impact**
A recommendation of the previous audit was to isolate and remove fundraising from intra-report categorisation, in line with the UHB notification to the Welsh Government that fundraising had been included in initial funding request schedules erroneously (a separate recommendation from the prior audit). Whilst a corrective notice was issued to the Welsh Government and the fundraising value was individually identified on the main cost report, there remains a concern that lack of a 'subtotal' presenting the pre-fundraised position, could lead to misinterpretation of the level of underspend shown on the report. It was also noted that lack of individual item commentary in relation to adverse variances (for example on equipment) could lead to missed opportunities to examine cost information. For example, where the September 2023 report showed an adverse variance of £146k on "Group 3" equipment – there was opportunity to report variances against the cost of major items of equipment – allowing greater understanding of the position and potential to challenge.	Potential risk that: • Clear information with appropriate granularity is not provided to the project to allow for adequate scrutiny and management of costs.

Recommendations		**Priority**
3.1	The Welsh Government funded element should be presented as a subtotal on the cost report – i.e., prior to the inclusion of fundraising.	**Low**
3.2	Include the breakdown of the cost to an item basis where large equipment or single items are contributing to a significant financial variance from FBC costings	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	Noted – will apply to other projects where this is relevant	30th November 2023	Associate Director of Capital Projects
3.2	Noted – will apply to other projects where possible	30th November 2023	Associate Director of Capital Projects

Matter Arising 4: Change Control Document Integrity (Design & Operation)	**Impact**
On all PMI's and PCFs the signature of the Project Manager / Project Director/ Project Associate Director was neither wet signed or processed and recorded by a version-controlled document management system such as Adobe sign or Docusign. Alternatively, emails were used to document the approval process. The Project Director initially did request for an electronic signing programme to be used but was advised that this could not be facilitated externally. The use of a recognised document signature software would improve controls. Initial Change Request Forms were noted to lack information regarding expected impact and, despite clear descriptions linking them to PMI's, PCF's and the Change Control Register the 'Change Log Number' field had not been populated. A sample of 24 Project Management Instructions (PMIs) were inspected and two PMI's were created significantly later than they were actioned: • PMI019 relating to a café omission, being formally recognised at revision 13 of the project despite being agreed and actioned in June 2023 during Revision 9 of the project. • PMI012 was created in August 2023 despite the contractor proposal notification being formalised in January 2023, and the change to works being recognised in funding of November 2022. Whilst it is recognised that the first example is an omission and the latter a zero financial impact change of specification which had received prominent exposure and review. We would still expect project changes to be administered in a timely manner.	Potential risk of: • Lack of control and oversight of change control processes • Non-compliance with the UHB's Standing Financial Instructions.

Recommendation		**Priority**
4.1	Change control documents should be signed/ authorised using a recognised document control programme.	**Medium**
4.2	Change Request Forms should be completed to include 'Change Log Number' field.	**Low**

4.3	All Project Manager Instructions (including zero value and omissions) should be completed in a timely manner as required by the contract.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	Noted – however the HB does not currently have access to such document control programmes. Will be considered for future projects including any cost implications. If it is not possible to progress with this, we will continue with email and ensure the email trail/ discussion is available for review as per this project.	30th November 2023	Associate Director of Capital Projects
4.2	Accepted – will ensure this is included in future project change control.	30th November 2023	Associate Director of Capital Projects
4.3	Noted – will endeavour to complete as recommended, however there will be some situations where it will not be possible to achieve the contractual timeline due to the complexity of the instruction/ change.	30th November 2023	Associate Director of Capital Projects

Appendix B: Follow-up of Previously Agreed Management Actions

Ref	Area	Previously Agreed Action	Current Status	Responsibility & Timescale	Priority
1.1	Cost Reporting	Treatment of charitable funding and application should be explicit in project cost reporting.	Complete – see MA 2.1	Associate Director of Capital Projects 31 January 2023	**Medium**
2.1	Governance	The PEP should be updated to reflect the current stage of the project.	Complete	Associate Director of Capital Projects 31 January 2023	**Low**
2.2	Governance	The role and responsibilities of the UHB roles of Senior Responsible Officer, Project Director, Project Manager etc., should be fully defined and approved by the Project Board.	Complete – See PEP V5 230829	Associate Director of Capital Projects 31 January 2023	**Medium**
2.3	Governance	Operation and membership of the commercial meetings should be defined at the Project Execution Plan to include (a) the requirement to minute meetings; (b) UHB officer membership; and (c) interaction with other key project groups e.g., the Project Team.	Complete – See PEP V8 230829	Associate Director of Capital Projects 31 January 2023	**Medium**
3.1	Contracts	The UHB should finalise Project Manager contract as soon as possible.	Complete	Associate Director of Capital Projects 31 January 2023	**Medium**
4.1	Change Control	The PEP should define the integration of the contractual change control procedures and the UHB's Scheme of Delegation.	Complete - Actioned during prior audit fieldwork	Associate Director of Capital Projects 31 January 2023	**Low**

Ref	Area	Previously Agreed Action	Current Status	Responsibility & Timescale	Priority
4.2	Change Control	The Change Control Form should be updated to enhance clarity of the decision process designating changes as 'for information or 'for action' prior to submission to Project Board	Complete – Assessed and no longer required within process	Associate Director of Capital Projects 31 January 2023	**Low**
5.1	Risk & Contingency Management	Risk registers should be formulated/updated for the current stage of the project, with project management, and contractual versions of the register corresponding for any common risks.	Complete	Associate Director of Capital Projects 31 January 2023	**Medium**
5.2	Risk & Contingency Management	Risk registers should include risk costs, risk owners (named individuals), and time parameters for risk mitigations.	Complete – Risk register owner is still stated in context of UHB/ SCP, Highlight report specifies owner on corresponding risk log	Associate Director of Capital Projects 31 January 2023	**Medium**
5.3	Risk & Contingency Management	To enhance reporting, an exception report should be published of targeted risk mitigations not achieved.	Complete – included in Highlight Report	Associate Director of Capital Projects 31 January 2023	**Low**

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	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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Asset Management Internal Audit Report

March 2024

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

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Auditors:	Stephen Chaney, Acting Head of Internal Audit Chris Scott, Internal Audit Manager
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Distribution:	Suzanne Jones, Interim AFD - Financial Strategy, planning Kelly Jones, Head of Capital Finance Sarah Humphries, Head of Business Assurance – Informatics
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 Chartered Institute of Public Finance & Accountancy in April 2023.

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

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

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Aneurin Bevan University Health Board (the Health Board) and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party. Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

This internal audit has been undertaken to provide an opinion over the effectiveness of the Health Board's processes to create and maintain accurate and up-to-date records of its equipment assets.

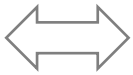
Overview

We noted the asset register (which is not an integrated module of the main financials) relies on manual processes for data capture and updating. This uses both paper flows from asset owners advising of additions, disposals and asset movements and capital spend analysis to update the equipment asset register. However, we found delays in the receipt of these change forms, leading to register inaccuracy.

The radio frequency (RFID) asset tagging process, which has now reached 67% of the eligible equipment base with a plan to complete by March 2025, improves asset management and, in particular, facilitates asset physical verification. However, as with the manual process, we found weaknesses persist around equipment disposal management, where controls need strengthening.

Matters arising are summarised in the table at the beginning of the next section and all of these are referenced in the main body of the report and detailed further in the matters arising and management actions table in Appendix A.

Report Classification

		Trend
Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	 Reasonable in 2015/16

Assurance summary[1]

Assurance objectives		Assurance
1	Policies & procedures	Substantial
2	Asset recording	Limited
3	Physical asset verification	Reasonable
4	Asset register/ accounts reconciliation	Substantial

Matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Equipment additions capture records	2	Operation	Medium
2	Asset disposal controls	2	Design	Medium
3	Physical verification of assets	3	Operation	High

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

1. Introduction

1.1 The review of Asset Management was completed in line with Aneurin Bevan University Health Board's (the 'Health Board') 2023/24 Internal Audit Plan.

1.2 Asset management is important in terms of both reducing the costs associated with assets and maximising the quality of services that those assets are used to provide.

1.3 Assets are recorded in the Real Asset Management (RAM) system (also known as and referred to as 'Asset4000') and identified through a radio frequency (RFID) tagging process.

1.4 RAM and electrical and biomedical engineering (EBME) systems both record the equipment assets and are linked by their RFID tag numbers.

1.5 Audit Wales' annual accounts review report, dated July 2023, stated that there remained a high volume of assets untagged, but that these were manually verified as existing as at 31 March 2023.

1.6 This audit was restricted in scope to the Health Board's plant and equipment assets.

1.7 The risks considered in this review included:

- loss or misappropriation of assets; and
- misstatement of physical asset holdings and/ or asset values.

2. Detailed Findings

Objective 1: Arrangements for fixed asset management, including the process for recording asset additions, movements and disposals, is documented within a financial control procedure

2.1 We sought to establish the scope, availability and currency of the Health Board's policy and procedure documentation that provides guidance for the teams managing assets.

2.2 Procedure documents cover a range of aspects of asset management including purchase, capitalisation, valuation, verification, disposal and record keeping as well as a description of key roles in the management of assets and their respective responsibilities.

2.3 We noted the procedure references the Health Board's Standing Financial Instructions and the Welsh Government IFRS NHS Wales Manual for Accounts and that the two key procedure documents we examined both recorded 2026 as their next review date.

Conclusion:

2.4 We have raised no matters arising under this objective relating to policy and procedure documentation and therefore have provided **substantial assurance** over this area.

Objective 2: the asset management system(s) is accurately updated to record asset additions, movements and disposals

2.5 We sought to establish the accuracy of asset records held by the Health Board through testing of a sample of equipment additions and disposals.

Additions

2.6 Fixed asset purchases are funded from the capital allocation and coded to designated cost centres in the Oracle accounting system denoting capital purchase through the routine procurement cycle.

2.7 Services purchasing assets (asset 'owners') are required to complete a Fixed Asset Additions Form to provide the Capital Finance Team with the details necessary to populate the asset register fields. These include the asset number, asset description, quantity, model, serial number, EBME reference, supplier name, manufacturer, capital programme cost centre, asset value and date purchased. Owners completing forms are required to sign and date these.

2.8 Secondly, the Capital Finance Team identify new assets through spend analysis as follows:

- each quarter the postings of spend to the Oracle capital expenditure suite of accounts are analysed;
- expenditure entries associated with existing assets are noted as additional spend to that asset in the register; and
- expenditure entries not associated with an existing asset are assigned a new sequential code and noted as a new asset.

2.9 Additions forms and analysis entries are matched and where the former has not been provided, these are sought from asset owners. New assets are then retrospectively added to the fixed asset register ('Asset4000' system, which is not part of the Oracle main financials) by the Capital Finance Team through a manual process.

2.10 We selected a sample of new assets from analysis schedules of capital spend during quarters one and two of 2023/24 and sought to identify these in the asset register. We found the following:

- all sample items were correctly transferred into the register and in the correct sum;
- for three of the 10 additions the service had not provided the Capital Finance Team with an additions form;

- one of the seven additions forms that were provided did not record an equipment item serial number; and
- the additions forms should be completed by asset owners at the time of the purchase. However, we were advised that it is common that they are not and have to be requested as part of the quarterly spend analysis exercise. Two of the seven additions forms were not dated, but dates on the other five forms post-dated the date of the addition in all cases.

(see **Matters arising 1**).

Disposals

2.11 Asset disposals are notified by the asset owners who complete a disposals form. These identify the item being sold, the reason for disposal and, if applicable, an estimate of sale proceeds. We noted that currently asset owners have the authority to dispose of the assets in their care without the need to seek approval to do so, which could represent a control risk (see **Matters arising 2**).

2.12 Owners completing disposal forms are required to sign and date these and the Health Board's policy states forms should be completed by the asset owner at the time of the asset disposal and forwarded to the Capital Finance Team. Anecdotally, forms are often completed at a later date and in some cases, only when physical verification checks have identified the assets are no longer held (see **Matters arising 2**).

2.13 Assets being disposed of that can be sold are auctioned through a retained auctioneer (proceeds are remitted to the Health Board and accounted for accordingly, but were not tested in this audit).

2.14 On receipt of the disposals form, the Capital Finance Team process the transaction within the ledgers and update the asset register.

2.15 We noted 160 assets with an aggregated net book value of £470,792 recorded in the equipment asset register as disposed of during 2023/24 (to date), at an aggregate loss of £428,735. However, we were advised that a substantial element of these disposal entries were linked to an exceptional flooding event that took place, currently the subject of a Welsh Risk Pool claim.

Movements

2.16 Asset owners are required to notify the Capital Finance Team of the movement of fixed assets to new locations, but we were advised very few asset movement forms are received from the service areas. Asset location records were included within the physical verification testing documented under audit objective three below.

Conclusion:

2.17 We noted a manual process operates to update the equipment asset register for additions, disposals and movements of assets. Accuracy and completeness of the register relies on timely notification of these transactions by asset owners. However, we found cases in sample testing where asset change documents were

received from owners some time after the event and because of the impact of this on register accuracy, we have provided **limited assurance** over this area.

Objective 3: Assets recorded on the asset register are physically verified on a periodic basis

2.18 We sought to establish the process adopted to verify the existence of the assets recorded in the registers.

2.19 We noted that the Health Board operates an annual physical verification review of their plant and equipment assets as part of the year end accounts / audit process.

2.20 At the close of the year 2022/23 the majority of assets were verified by asset owners in the following process:

- the Capital Finance Team send each service team an extract of the asset register containing the assets they own;
- owners are asked to verify whether assets listed still exist, have been disposed of or transferred by annotating and returning the spreadsheet extract; and
- where assets have been disposed of or are no longer held, owners are asked to complete a disposals or transfer form as applicable to enable the Capital Finance Team to update the asset register.

2.21 A programme of asset tagging began in 2022/23 and assets tagged during the years 2022/23 and 2023/24 were excluded from the year end owner verification exercise (at the time of this audit the 2023/24 owner verification cycle had not been carried out). We noted that as at November 2023, 67% (Gross Book Value (GBV)) of register assets suitable for tagging had been tagged.

2.22 In 2022/23 we noted that through a combination of owner verification (54%) and asset tagging (28%), 82% (GBV) of the full equipment asset register was verified.

2.23 Additionally, this year for the first time, a proportion of tagged assets have been physically verified by a wireless electronic process. This involves visiting asset sites with a scanning device that captures and logs tagged assets and their locations and automatically updates the asset register and EBME MEDUSA systems.

2.24 We noted that the Capital Finance Team have a documented plan in place to complete the tagging of the remaining assets in the register. Originally targeted for completion by March 2024, we were informed that staffing movements and other workload pressures have meant that this is now provisionally delayed to March 2025.

2.25 We conducted two-way physical verification testing on a random sample basis (20 assets) to assess the level of risk of misstatement within the equipment asset register and found the following:

- five (four of the 10 non-tagged sample assets and one of the 10 tagged sample assets) of the 20 assets selected from the register could not be

identified, either at the site indicated nor elsewhere at the time of the audit; and

- two of the 20 assets picked at random at the sites visited could not be subsequently identified in the register.

(see **Matter arising 3**).

Conclusion:

2.26 We have raised one matter arising under this objective relating to the accuracy/ completeness of the equipment asset register against physical assets held at visited sites and therefore have provided **reasonable assurance** over this area.

Objective 4: The asset register is reconciled to the financial ledger / records

2.27 We sought to establish the control process in operation to validate the equipment asset register balances by reconciliation to the Health Board's financial ledger.

2.28 We noted a reconciliation process operates to a monthly cycle which is subjected to review and approval by the Head of Capital Finance.

2.29 We reviewed the reconciliations of the months April to October 2023 and challenged and obtained explanations for any significant reconciling items.

2.30 We noted a number of reconciling items that were explained by timing differences between postings to the two records but did not identify any errors or exceptions.

Conclusion:

2.31 We have raised no findings relating to equipment asset register and financial ledger reconciliation and therefore have provided **substantial assurance** over this area.

Appendix A: Management Action Plan

Matter arising 1: Equipment additions capture records (Operation)	Impact
We selected a sample of new assets from analysis schedules of capital spend from quarter one and quarter two of 2023/24 and sought to identify these in the asset register. We found the following: • all sample items were correctly transferred into the register and in the correct sum; • for three of the 10 additions the service had not provided an equipment additions form; • one of the seven additions forms that were provided did not record an equipment item serial number; and • additions forms should be completed by asset owners at the time of the purchase, but we were advised that it is common that they are not and have to be requested as part of the quarterly spend analysis exercise. Two of the seven additions forms were not dated, but dates on the other five forms were post-dated, some significantly.	Potential risk that the record of the equipment in the asset register is inaccurate or incomplete.

Recommendations	Priority
1.1 We recommend that additions forms are obtained from asset owners promptly following equipment purchase and that forms with missing data are returned to owners for completion.	Medium

Management Responses	Target Date	Responsible Officer
1.1 The Capital Finance Team include the new asset form on the Capital Scheme approval email that is sent out to the responsible budget holder when a new equipment purchase is approved. The email requests the form be completed when the new equipment asset is received and returned to the Capital Finance Team. New assets are added to the Fixed Asset Register each quarter. Any missing forms are subsequently chased with the owning department. This process has significantly increased the number of forms received over the past two years. In addition to the above, the Capital Finance team will include a list of missing forms as an agenda item for each monthly divisional meeting and will return forms where information is incomplete. General Managers to ensure that forms are completed and returned to Capital Finance.	April 2024	Head of Capital Finance & General Managers.

Matter arising 2: Asset disposal controls (Design)	Impact
We noted that currently asset owners have the authority to dispose of the assets in their care without the need to seek approval to do so, which under some circumstances could represent a control risk. Where equipment is being scrapped or donated there may be little or no records that evidence what has taken place.	Potential risk of undetected misappropriation of equipment.

Recommendations	Priority
2.1 We recommend where assets are disposed of and are not being sold, or where disposal forms are completed retrospectively after an asset has not been found in a physical verification test, that asset owners are required to obtain the countersignature of their manager on the disposal form.	Medium

Management Responses	Target Date	Responsible Officer
2.1 To ensure all asset disposals are approved appropriately prior to disposal, a counter signature from the General Manager for the Division will be added to the disposal form and the Financial Control Procedure will be amended accordingly. The policy change will need to be reported to and approved by the Audit Committee.	April 2024	Head of Capital Finance General Managers

Matter arising 3: Physical verification of assets (Operation)	Impact
We conducted two-way physical verification testing of Health Board equipment assets, on a random sample basis to assess the level of risk of misstatement within the equipment asset register and found the following: • ***Register to physical asset***: five (four non-tagged sample assets, one tagged sample assets) of the 20 assets selected from the register could not be physically identified at the time of the audit, either at the site indicated in the register nor elsewhere. • ***Physical asset to register:*** two of the 20 assets picked at random at the sites visited could not be subsequently identified in the register.	Potential misstatement of the Health Board's equipment assets.

Recommendations	Priority
3.1 We recommend that the Health Board examine each exception individually and take appropriate action to rectify the matter when the reason for the anomaly is determined. All items that were not found in the register during a physical asset test should be accounted for. Asset owners that did not submit a disposal form at the time of the disposal should be required to provide documentation to evidence the disposal method and to corroborate what took place.	**High**

Management Responses	Target Date	Responsible Officer
3.1 Agree. These issues will be resolved in readiness for the end of year accounts and disposal forms requested for those assets that cannot be located.	31st March 2024	Head of Capital Finance

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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Risk Management
Final Internal Audit Report
April 2024

Aneurin Bevan University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
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Shared Services Partnership
Audit and Assurance Services

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

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Auditors:	Stephen Chaney, Acting Head of Internal Audit Laura Howells, Principal Internal Auditor
Executive sign-off:	Rani Dash, Director of Corporate Governance
Distribution:	Rani Dash, Director of Corporate Governance Lucy Windsor, Head of Corporate Risk & Assurance
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 Chartered Institute of Public Finance & Accountancy in April 2023

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

Disclaimer notice - please note
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Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Aneurin Bevan University Health Board (the Health Board) and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

To assess on the effectiveness of the risk management and assurance arrangements in place within the Health Board in order to ensure that strategic objectives are achieved.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Risks should be migrated to Datix when the necessary Datix upgrades are made.
- An overarching Directorate risk register should be compiled. There should be a clear and documented process of review of the risk register. This can be achieved when risks are migrated to Datix.

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

There is a clear escalation process in place enabling risks to be effectively reviewed at an appropriate level.

Risks are being appropriately scored and updated with actions and updates regularly provided.

Report Opinion

		Trend
Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	2022/23

Assurance summary[1]

Objectives		Assurance
1	Identification of risks	Reasonable
2	Escalation of risks	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	Datix	1	Design	Medium

1. Introduction

1.1 The Risk Management review was completed in line with the 2023/24 Internal Audit Plan. The review sought to provide Aneurin Bevan University Health Board (the 'Health Board') with assurance that appropriate risk management arrangements are in place within the divisions.

1.2 Risks that were considered as part of the review:

- key risks are not identified, assessed, recorded and / or escalated throughout the Health Board;
- risks identified are not effectively managed resulting in patient harm / poor patient experience, increased financial costs and / or reputational damage to the Health Board;
- lack of awareness of the Risk Management Strategy and Framework.

1.3 This audit focused on the management of divisional risks, specifically within the Digital Directorate.

2. Detailed Audit Findings

Objective 1: Risks at a divisional / service level are appropriately identified, assessed and monitored in accordance with the Framework.

2.1 Risks are identified and managed within each of the 'domains' or teams across the Directorate e.g. Strategy, Planning & Design, Digital Programmes, Service Delivery, Information Services, etc and are escalated through local risk management processes to the appropriate Assistant Director.

2.2 The Digital Programmes department has developed a Risk Management Approach and Risk Escalation process to support identifying and managing risk via the Programmes Risk. These documents identify but are not limited to:

- roles and responsibilities relating to risk;
- the risk escalation/reporting process;
- risk register requirements;
- actions to be taken to be inline with corporate risk management processes; and
- how to grade risks.

2.3 Risks are not held on Datix, but rather, spreadsheets maintained on SharePoint. There is no Directorate-wide risk register. Instead, there are 'team' risk registers and a single risk register for all projects and programmes. There are six risk registers in place in total. Although separate, all risk registers clearly use the standard 5 x 5 risk scoring matrix to score risks as defined in the Health Board's Risk Management Policy and are prioritised on this basis.

2.4 This approach is in place as the Directorate has been waiting for the implementation of the All-Wales risk management module within Datix. Since December 2023, discussions have been underway with the Head of Corporate Risk

& Assurance around the use of Datix for Directorate-wide risk management. The Directorate is awaiting an update to the system, aligned to the new corporate risk management policy and strategy before a planned migration of risks into Datix. **Matter arising 1**.

2.5 We were informed that regular checks of due dates for review of risks, and their mitigation / action updates are carried out by teams. There is no evidence of this review. However, through review of the six risk registers we identified:

- risks were appropriately scored using the approved scoring matrix;
- risks were allocated a responsible officer/actioner;
- risks were regularly added to the risk registers;
- mitigating actions noted and progress updates; and
- review dates of actions were missing in a number of instances but there was evidence risks are regularly updated.

2.6 The Senior Directorate Team meet on a monthly basis and risk escalation is a standard agenda item at that meeting. Review of the agenda and minutes confirmed risks are reviewed and discussed at each meeting. However, there is a lack of an audit trail identifying where individual risk registers are reviewed and scrutinised.

Conclusion:

2.7 Risks are appropriately managed and scored. There is scope to streamline the number of risk registers by migrating risks to Datix, therefore we have given this area **reasonable assurance**.

Objective 2: There is appropriate management of risks identified at a divisional level, including any escalation required.

2.8 As noted above, the Digital Directorate has developed and implemented an escalation process for identified risks. Through discussion with staff, we were informed that risks can also be escalated through project health check meetings and project / programme board meetings. As the process is automated via Sharepoint, notifications are issued following the completion of the escalation field against each risk. In addition, we observed frequent action updates to risks recorded.

2.9 The Digital Directorate has escalated one item (in three sections) to the Strategic Risk Register. Updates are coordinated by the Portfolio Analyst on a monthly or quarterly basis (depending on the risk score). Reminders are set for the first Monday of each month for the lead of each risk section requiring an update. These updates are then returned to the Corporate Governance Team.

2.10 Review of the Audit and Risk Committee minutes confirmed the strategic risk identified is brought to the attention of senior management and discussed at an appropriate level.

Conclusion:

2.11 There is a clear process for escalating risks further within the Health Board, therefore we have provided **substantial assurance** over this area.

Appendix A: Management Action Plan

Matter Arising 1: Datix (Design)			**Impact**
Risks are not held on Datix, but rather, spreadsheets maintained on SharePoint. This approach is in place as the Directorate has been waiting for the implementation of the All-Wales risk management module within Datix. Since December 2023, discussions have been underway with the Corporate Governance Team regarding the use of Datix for Directorate-wide risk management. The Directorate is awaiting an update to the system, aligned to the new corporate risk management policy & strategy before a planned migration of risks into Datix.			Potential risk of: • Risks being lost or inappropriately modified. • No ability of comparability between Divisions
Recommendations			**Priority**
1.1	The Digital Directorate should ensure that there is no additional risk exposure through the current approach of recording divisional risks. Risks should be migrated to Datix as soon as functionality within the software becomes available.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	The Health Board is still waiting for an implementation date for the Once for Wales Risk Module (RLDatix). In the interim, the Head of Corporate Risk and Assurance is working with the Head of Health and Safety to improve the risk reporting form on the Datix legacy system, as the current format is onerous, overly complicated, and easy to override required sections. The Once for Wales Datix Risk Module is being trialled in Powys and has been well received; thus, the risk recording form from the RLDatix system will be replicated in the Datix legacy system to aid in the migration of locally held risk registers to Datix. The Digital Directorate will test the new form by adding all its risks to Datix. Training on the Datix system will be provided to ensure that all Datix Users within the Directorate understand how to use the system to manage risks and run reports to gain insight into the Directorate's risk exposure.	30 September 2024	**Head of Corporate Risk and Assurance / Assistant Director of Digital Programmes**

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	Unsatisfactory	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*
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Long Term Sickness Absence Management

Final Internal Audit Report

March 2024

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

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Executive sign-off:	Sarah Simmonds, Director of Workforce and Organisation Development
Distribution:	Shelly Williams, Assistant Director of Workforce & OD
Committee:	Audit, Risk and Assurance Committee

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Executive Summary

Purpose

The purpose of the audit was to review the compliance with the NHS Wales Managing Absence at Work Policy. This was not an audit on the number of sickness absence episodes but whether the Health Board is acting promptly and managing the interests of all parties within the process of managing long term sickness absence.

Overview

We have issued reasonable assurance on this area. The audit focused on the application of the NHS Wales Managing Attendance at Work Policy and the management of long-term sickness absence across the Health Board. We found the policy is being applied correctly, alongside additional actions to aid staff in implementing the policy. These actions include training, sickness absence groups and deep dives to assist with the design of action plans. We also found pockets of good practice, which assist staff's wellbeing.

The matters requiring management attention include:

- The review of the NHS Wales Managing Attendance at work Policy: Information Pack to ensure it is up to date, as it was up for review in November 2021.
- Instances across the Health Board where the policy has not been completed fully which need to be reinforced.

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

Report Opinion

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

Assurance summary[1]

Objectives		Assurance
1	Adherence to NHS Wales Managing Absence at Work Policy	Reasonable

[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	NHS Wales Managing Attendance at Work Policy: Information Pack	1	Design	Low
2	Application of Policy	1	Operation	Medium

1. Introduction

2.1 The review for long term sickness absence management was completed in line with the 2023/24 Internal Audit Plan. The NHS Wales Managing Absence at Work Policy (the 'Policy') directs Aneurin Bevan University Health Board (the 'Health Board') on how to manage long term sickness absence within the organisation. In particular, the main objectives for the Policy are "to support the health and wellbeing of employees in the workplace, support employees to return to work following a period of sickness absence safely and as quickly as possible and support employees to sustain their attendance at work."

1.1 The risks in this review included:

- Increased sickness absence levels, resulting in service delivery difficulties;
- Impact on staff morale and wellbeing from increased workload;
- Increased risk of patient harm because of the lack of substantive staff; and
- Adverse impact on financial and non-financial resources throughout the health board.

2. Detailed Audit Findings

Objective 1: Adherence to the requirements and objectives of Section 4 (and other relevant sections) of the NHS Wales Managing Attendance at Work Policy

2.2 The Health Board has adopted the NHS Wales Managing Attendance at Work (MAAW) Policy. The Policy is readily available to all Health Board employees via the SharePoint site. It is noted that the policy was due for review several years ago (December 2021). We acknowledge that as an NHS Wales policy this would require the Welsh Partnership forum to review, approve and distribute the document. The Health Board has the NHS Wales Managing Attendance at work: information pack (the 'pack') which is aligned to the policy.

2.3 As part of the audit, we reviewed an Electronic Staff Record (ESR) report detailing all long term (more than 28 days) sickness episodes, covering a 12-month period from January to December 2023. The report included all 'open' (staff were still absent from work) and 'closed' (staff had since returned to work) long term absences. This was to test the completeness of the process.

2.4 The management of a long-term sickness absence differs from that of a short-term episode by there being more emphasis upon communication and contact between the staff member and line manager.

2.5 A sample of 21 individuals was selected at random and included a range of sickness lengths from just over 28 days through to absences more than 365 days.

2.6 We selected a coverage throughout different service areas within the Health Board, including:

Division / Department	Sample size
Clinical Support Services	2
Facilities	5
Family & Therapies	4
Medicine	2
Mental Health & Learning Disabilities	1
Primary Care & Community Services	4
Scheduled Care	2
Urgent Care	1

Information pack:

2.7 The Health Board's pack is aligned to the policy and contains all the necessary information to manage long-term sickness absences. This information sets out the process, definitions, and templates to utilise when managing absence. The documentation is hosted on the Health Board's SharePoint for managers to use.

2.8 The review date for the pack states November 2021 and has not been reviewed since it was written in November 2018. Whilst it is still aligned with the policy, there are some changes which require updating. The main one being about the Occupational Health referral process which has now moved from a paper-based process with a signed form to an electronic referral process.

The above points are included within **matter arising one.**

Application of Policy:

2.9 During testing we confirmed that managers are very familiar with the policy and process and are using it effectively and in a compassionate manner. Overall, there is evidence of good, regular contact between managers and staff members, through face-to-face meetings and emails. Whilst phone calls, WhatsApp and text messages are used for general keeping in touch updates and wellbeing conversations, we confirmed that formal records were being maintained too. For example, the completion of contact forms, together with fit notes being retained on personnel files and return to work discussions completed.

2.10 We requested the names of managers / supervisors for the sample tested. From twenty-one sickness absences tested we found sixteen members of staff did not have the correct manager recorded on ESR. This in turn required additional work to try and locate the correct manager to discuss the relevant member of staff's

long term sickness absence. We also discussed with each manager the process they adopted for the management of long-term sickness absence episodes. We found that there was a good understanding of the process and in addition, felt there was support from the Workforce and OD Team, when required.

2.11 However, during testing we identified instances where the application of the policy was not fully adhered to. These are listed below, but primarily focused on the outcome letters not being completed, following sickness meetings with the staff member. Furthermore, where they were completed, it was difficult to determine if Occupational Health referrals had been completed or not.

2.12 We also found that it was not always clear if the recommendations from Occupational Health or the Workforce and OD team had been discussed and / or implemented. For example, whether phased return, redeployment, flexible working and / or wellbeing assistance options had been offered to the staff member.

The above points are included within **matter arising two.**

Communication:

2.13 We saw strong evidence of good communication taking place across the Health Board between staff and managers from the moment the sickness absence commenced onwards. This included regular updates provided by staff to managers through many different platforms, up to date sick notes, meeting invitation letters being sent and monthly sickness meetings taking place to discuss plans to return to work.

2.14 There is evidence of good communication regarding the promotion of wellbeing and helping staff to remain at work. This can be seen within the Health Board's People Plan (the 'Plan'), with its first key deliverable for 2022-25 being focused on staff health and wellbeing, which sometimes can contribute towards long term sickness. The focus within the Plan is also for the manager to engage and actively listen to staff and consider appropriate action(s).

General Observations:

2.15 During the audit we were informed of the good support provided by the Workforce and OD team when required. This was provided in the form of policy guidance and attendance at sickness meetings, when required.

2.16 Within the Workforce and OD team, internal meetings monitor the Workforce Dashboard and long-term sickness absence hotspots. These groups have been operating for over a year and seek to improve sickness absence rates. This is led by a 12-month action plan, with a series of 'deep-dive' reviews into service areas.

2.17 Training in Managing Attendance at work has recently been operating throughout the Health Board. Details of which are on the SharePoint site and so far, there has been good demand for the training, with more dates provided. All managers with the responsibility for absence management should attend the training. This will often be addressed locally through one-to-one discussions. Workforce and OD team coach new managers withing Divisions so they are effectively trained and coached through real cases working alongside one of the Workforce and OD team.

Good Practice:

2.18 We came across the Facilities Divisional Business Unit (DBU) which takes an active role in the management of long-term sickness along with supporting management with the administration of E-Systems, ESR and Health Roster and supporting the process of PADRs and payroll. All sickness absences within the Facilities division are processed with the DBU, where the team manage sickness absence meeting invitations and outcome letters. Reports are also generated to monitor outstanding steps within the process that are yet to be completed.

2.19 We also found that Pathology is in the process of finalising a standard operating procedure (SOP) focused on raising concerns, with a confidential number for staff to call if they wish to discuss any work or personal related matters which may be affecting them. Alongside this, we were informed of "Wellbeing Wednesdays" within acute medicine to help and support junior doctors.

Conclusion:

2.20 We found the application of the policy generally positive throughout the Health Board, with training offered to service areas that require support. Alongside this, we observed some examples of good practice, particularly within Facilities, Pathology, and acute Medicine. However, the testing does highlight some instances where the process has not been fully completed and these need to be addressed going forward. Therefore, we have provided **reasonable assurance** for this objective.

Appendix A: Management Action Plan

Matter Arising 1: NHS Wales Managing Attendance at Work Policy: Information Pack (Design)	**Impact**
The NHS Wales Managing Attendance at Work (MAAW) Policy (the 'Policy') has been adopted across all NHS organisations. There is a Health Board Information Pack (the 'Pack') in place, which compliments the Policy that was issued in November 2018. The review date for the Pack was November 2021, but this has not yet been completed. The Pack is widely used across the Health Board by managers to assist with the contact logs, contact sheets, sickness absence meeting sheets and letters templates. Overall, the information in the Pack is consistent with the Policy, however reference made to the Occupational Health process is slightly outdated. As it states in Appendix 17 that an Occupational Health Form should be completed, signed and sent. However, now it is an electronic process.	Potential risk of: • Managers using the information pack are not being given the correct information.

Recommendations		**Priority**
1.1a	The Health Board should review the Pack to ensure it is up to date and in line with the Health Board's processes and remains fully aligned to the NHS Wales Managing Attendance at Work Policy.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
1.1a	To update the pack, to include the enhanced OH referral process and any other appropriate updates, whilst recognising that the pack predicates on the policy, which requires national approval and update.	30 June 2024	Director of Workforce and OD

Matter Arising 2: Application of Policy (Operation)	**Impact**
We selected a sample of 21 long term sickness episodes for testing, across the following service areas. **Division / Department** — How many in sample: Clinical support services: 2 Facilities: 5 Family & Therapies: 4 Medicine: 2 Mental Health & Learning Disabilities: 1 Primary Care & Community Services: 4 Scheduled Care: 2 Urgent Care: 1 We found that the Policy was largely applied throughout the sample tested, with the following exceptions / observations identified. • sixteen ESR details are not correct for line manager / supervisor purposes; • five outcome letters following sickness meetings were not completed; • two instances where the return-to-work process was not completed; • three instances where it was not possible to determine if Occupational Health referrals had been made or not; • four examples where we were unable to determine if recommendations from Occupational or the Workforce and OD Team had been implemented; and • five instances where we were unable to determine if flexible working arrangements had been offered to assist with the employee's return to work.	Potential risk of: • Long term sickness process not adhered to, and staff provided with the support and guidance required.

Recommendations		Priority
2.1a	The Health Board should encourage staff to ensure manager details are correct on ESR for all employees.	**Medium**
2.1b	There should be regular communications with divisions and prompts to ensure long-term sickness is managed effectively and all steps of the process are completed fully and correctly.	

Agreed Management Action		Target Date	Responsible Officer
2.1a	Periodic reminders to update details including manager details will be published on ESR portal. In additional, annual report to be run for review by division on manager allocation in ESR	30 April 2024	Director of Workforce and OD
2.1b	Review training material to ensure that all issues above are included. Long term sickness process to be updated in "the pack" plus internal sickness absence group to produce regular comms/tips on effectively managing and supporting staff who are absent.	30 June 2024	Director of Workforce and OD

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Follow-up of High Priority Recommendations

Final Internal Review Report

April 2024

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

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Final report issued:	5th April 2024
Auditors:	Stephen Chaney, Acting Head of Internal Audit Laura Howells, Principal Internal Auditor
Executive sign-off:	Rani Dash, Director of Corporate Governance
Distribution:	Rani Dash, Director of Corporate Governance Lucy Windsor, Head of Corporate Risk & Assurance
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 Chartered Institute of Public Finance & Accountancy in April 2023

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

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

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

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

Executive Summary

Purpose

To assess whether high priority internal audit recommendations have been implemented and the completeness and accuracy of the updates provided to the Audit, Risk and Assurance Committee via the Audit Recommendation Tracking Tool (the 'Tracker').

Overview

We reviewed whether any 2022/23 internal audit recommendations, scheduled to be completed after October 2022 and any 2023/24 recommendations due for completion before October 2023 had been implemented / recorded onto the Health Board's Tracker.

Overall, we found that the process for updating the Tracker and extending recommendation deadlines is clear.

However, we have made some suggestions for consideration, to ensure the Tracker remains fully accurate, including a periodic completeness review of actions included within the Tracker and the ongoing appropriateness of the action implementation timeframes.

Report Opinion

		Trend
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.	N/A

1. Introduction

1.1 The Follow-up of High Priority Recommendations review was completed in line with the 2023/24 Internal Audit Plan. The review sought to determine if a sample of high priority recommendations had been implemented appropriately and in a timely manner by Aneurin Bevan University Health Board (the 'Health Board').

1.2 Risks considered as part of this review include:

- failure to implement agreed high priority audit recommendations in a timely manner;
- increased financial, clinical, statutory and reputational risk for the Health Board; and
- inaccurate reporting of the Tracker within the Health Board.

1.3 The scope of this follow-up review has not provided assurance against the full scope and objectives of the original audits. The 'follow-up review opinion' provides a summary status against the level of implementation of the identified actions and outstanding recommendations.

2. Detailed Review Findings

Objective 1: the level of implementation of the high priority recommendations raised during the 2022/2023 and 2023/2024 financial year that were due to be completed before October 2023

2.1 We reviewed the current position of the 23 recommendations due for completion after October 2022 and before October 2023. From the 23 high priority recommendations raised previously, we agreed with the current position / tracking of all recommendations, with no adjustments required.

2.2 There was one recommendation in relation to the 2022/23 Clinical Audit report which was not included within the Tracker. However, through further investigation we identified the action to be closed with the appropriate evidence in place. We suspect a clerical error and the crossover between other Clinical Audit recommendations was the underlying reason for it not being included within the Tracker.

2.3 It was noted that a larger number of actions had been closed this year (13 actions) compared with the same follow-up review last year (seven actions).

Conclusion:

2.4 We found that management actions are being closed when appropriate evidence is in place. However, management should review the Tracker to ensure that all actions are included.

Objective 2: the completeness and accuracy of the updates provided to the Audit, Risk and Assurance Committee via the Audit Action Tracker (the 'Tracker')

2.5 We tested the completeness of the Tracker and found that it is regularly updated for each Audit, Risk and Assurance Committee (the 'Committee'). The Head of Corporate Risk and Assurance discusses the position of outstanding high actions with relevant staff prior to the Tracker being updated. A status update is provided to the Committee.

2.6 The Tracker includes a column for a deadline extension. The original recommendation deadline is noted and where an extension is requested, a new deadline is set. Extensions are presented and discussed to the Committee, with appropriate challenge taking place when required.

2.7 Six out of the seven actions sampled that were noted as still ongoing, were overdue for completion. The Tracker holds progress updates on each of these actions and each has been updated with progress recently. We were informed that the new deadlines for completion would be updated at the next Committee in April, as this is the designated forum for extending deadlines when required.

2.8 There is evidence the Tracker is adjusted regularly with status updates. Justification is noted when action deadlines are extended.

Conclusion:

2.9 The Tracker should continue to be regularly reviewed, to ensure actions are completed within their designated closure period and any exceptions have an updated and appropriate deadline for completion.

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Annual Internal Audit Plan

Internal Audit Charter

april 2024

Aneurin Bevan University Health Board

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1. Introduction

This document sets out the Internal Audit Plan for 2024/25 (the 'Plan') detailing the audits to be undertaken and an analysis of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

The Accountable Officer (the 'Health Board Chief Executive') is required to certify, in the Annual Governance Statement, that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit, Risk and Assurance Committee, with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the findings and recommendations from internal audit reviews may be used by Health Board management to improve governance, risk management, and control within their operational areas.

The Public Sector Internal Audit Standards (the 'Standards') require that 'The risk-based plan must take into account the requirement to produce an annual internal audit opinion and the assurance framework. It must incorporate or be linked to a strategic or high-level statement of how the internal audit service will be delivered in accordance with the internal audit charter and how it links to the organisational objectives and priorities.'

Accordingly, this document sets out the risk-based approach and the Plan for 2024/25. The Plan will be delivered in accordance with the Internal Audit Charter and the agreed KPIs which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

The proposed Plan includes assurance audits on some services that are provided by DHCW, NWSSP, WHSSC and EASC on behalf of NHS Wales. These audits will be included in Appendix A when agreed formally. These audits are part of the risk-based programme of work for DHCW, NWSSP and Cwm Taf Morgannwg UHB (for WHSSC and EASC) but the results, as in previous years, are reported to the relevant Health Boards, Trust and SHAs and are used to inform the overall annual Internal Audit opinion for those organisations.

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

The Plan has been developed in accordance with Standard 2010 – Planning, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals;
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks;
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;
- confirmation of the audit resources required to deliver the Internal Audit Plan;
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk-based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering:

- the organisation's risk assessment and maturity;
- the organisation's response to key areas of governance, risk management and control;
- the previous years' internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

Our planning takes into account the NHS Wales Planning Framework and other NHS Wales priorities and is mindful of significant national changes that are taking place, in particular the significant backlog in NHS treatment. In addition, the plan aims to reflect the significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP) and Annual Plan and other changes within the organisation, assurance needs, identified

concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging issues throughout the year. Any necessary updates will be reported to the Audit, Risk and Assurance Committee in line with the Internal Audit Charter.

While some areas of governance, risk management and control will require annual consideration, our risk-based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the 'audit universe'). The risk associated with each auditable area is assessed and this determines the appropriate frequency for review.

In addition, we will, if requested, also agree a programme of work through both the Board Secretaries and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at Health Boards only.

Therefore, our audit plan is made up of a number of key components:

1) Consideration of key governance and risk areas: We have identified a number of areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover the Governance and Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management and an overall IM&T assessment. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing or further work where required.

2) Organisation based audit work – this covers key risks and priorities from the Board Assurance Framework and the Corporate Risk Register together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.

3) Follow up: this is follow-up work on previous limited and no assurance reports as well as other high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.

4) Work agreed with the Board Secretaries, Directors of Finance, other executive peer groups, or Audit Committee Chairs in response to common risks faced by a number of organisations. This may be advisory work in order to identify areas of best practice or shared learning.

5) The impact of audits undertaken at other NHS Wales bodies that impacts on the Health Board, namely NHS Wales Shared Services Partnership (NWSSP), Digital Health and Care Wales (DHCW), WHSSC and EASC.

6) Where appropriate, Integrated Audit & Assurance Plans will be agreed

for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the Final Business Case for major capital bids.

These components are designed to ensure that our internal audit programmes comply with all of the requirements of the Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to the Health Board's systems of assurance

The risk based internal audit planning approach integrates with the Health Board's systems of assurance; therefore, we have considered the following:

- a review of the Board's vision, values and forward priorities as outlined in the Annual Plan and three year Integrated Medium Term Plan (IMTP);
- an assessment of the Health Board's governance and assurance arrangements and the contents of the corporate risk register;
- risks identified in papers to the Board and its Committees (in particular the Audit, Risk and Assurance Committee and the Patient Quality, Safety and Outcomes Committee);
- key strategic risks identified within the corporate risk register and assurance processes;
- discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility;
- cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions);
- new developments and service changes;
- legislative requirements to which the organisation is required to comply;
- planned audit coverage of systems and processes provided through NWSSP, DHCW, WHSSC and EASC;
- work undertaken by other supporting functions of the Audit, Risk and Assurance Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV) where appropriate;
- work undertaken by other review bodies including Audit Wales and Healthcare Inspectorate Wales (HIW); and
- coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with a number of Health Board Executives and Independent members to discuss current areas of risk and

related assurance needs. Meetings have been held, and planning information shared, with the Health Board's Executive team, the Chair of the Audit, Risk and Assurance Committee and the Chair of the Board.

The draft Plan has been provided to the Health Board's Executive Management Team to ensure that Internal Audit's focus is best targeted to areas of risk.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on both our and the organisation's assessment of risk and assurance requirements as defined in the Board Assurance Framework and Corporate Risk Register.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal controls). Our assessment also takes into account corporate risk, materiality or significance, system complexity, previous audit findings, and potential for fraud.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2024/25

The Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings. It is structured under the six components referred to in section 2.2.

Where appropriate the Plan makes cross reference to key strategic risks identified within the corporate risk register and related systems of assurance together with the proposed audit response within the outline scope.

The scope, objectives and audit resource requirements and timing will be refined in each area when developing the audit scope in discussion with the responsible executive director(s) and operational management.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management, and Audit Wales requirements if appropriate.

The Audit, Risk and Assurance Committee will be kept appraised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Audit, Risk and Assurance Committee meeting.

The majority of the audit work will be undertaken by our regionally based teams with support from our national Capital & Estates team, in terms of capital audit and estates assurance work, and from our IM&T team, in terms of Information Governance, IT security and Digital work.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose. To this end, the need for flexibility and a revisit of the focus and timing of the proposed work will be necessary at some point during the year.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan to enable Internal Audit to respond to emerging risks and priorities identified by the Executive Team and endorsed by the Audit, Risk and Assurance Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit, Risk and Assurance Committee for approval.

Regular liaison with Audit Wales as your External Auditor will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

The plan has been put together on the basis of the planning process described in this document. The plan includes sufficient audit work to be able to give an annual Head of Internal Audit Opinion in line with the requirements of Standard 2450 – Overall Opinions.

Audit & Assurance Services confirms that it has the necessary resources to deliver the agreed plan.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

If additional work, support or further input necessary to deliver the plan is required during the year over and above the total indicative resource requirement a fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit, Risk and Assurance Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by the Health Board, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

In addition, any capital audit work in relation to specific projects will be charged for separately on the basis of a separately agreed Integrated Audit & Assurance Plan. Where this is the case, a provision for this work would have been included by the Health Board in its business case submission.

6. Action required

The Audit, Risk and Assurance Committee is invited to consider the Internal Audit Plan for 2024/25 and:

- approve the Internal Audit Plan for 2024/25;
- approve the Internal Audit Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Stephen Chaney
Head of Internal Audit
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2024/2025

Planned output	Audit Ref	Strategic Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Financial Sustainability	1	SRR001 SRR001g SRR001h	To determine if appropriate recovery plans are in place to achieve a sustainable financial position, including the impact of any associated reduction in non-recurrent public health funding.	Director of Finance, Procurement and Value / Director of Public Health and Strategic Partnerships	Q3
IMTP – Service Delivery Plans	2	SRR001	To provide an opinion over the arrangements in place for developing IMTP deliverables based on models of data e.g. demand and capacity.	Director of Strategy, Planning and Partnerships	Q2
Contract Management	3		To determine if contract management controls are operating effectively, including engagement with stakeholders.	Chief Operating Officer	Q4
Facilities Stock	4	SRR001	A dedicated follow-up review over the implementation progress of the recommendations raised within the 2023/24.	Chief Operating Officer	Q2

Planned output	Audit Ref	Strategic Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Performance Framework	5		To provide assurance over the new performance framework, including escalation arrangements.	Director of Strategy, Planning and Partnerships	Q3
Embedding of Policies	6	SRR008	To ensure the Serious Incident Policy and Whistleblowing Policies have been fully implemented.	Director of Nursing	Q2
Declarations of Interest	7		To provide assurance over the arrangements for registering and managing potential conflicts caused by the receipt of gifts, hospitality and external interests.	Director of Corporate Governance	Q1
Divisional Governance Arrangements	8		A review of the governance arrangements in place within divisions (excl. Mental Health and LD), to ensure key risks / matters arising are escalated and / or managed effectively.	Chief Operating Officer	Q2
Directorate Review - Mental Health and Learning Disabilities	9	SRR003	A review to ensure that arrangements from the 90 day plan for the division have been embedded.	Chief Operating Officer	Q2
Maternity Services Improvement Plan	10	SRR005	A continuation from the 2023/24 internal audit of Maternity Services Action Plan, to ensure that external	Director of Nursing	Q3

Planned output	Audit Ref	Strategic Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
			recommendations raised are on track to being fully implemented.		
End of Life Care	11		To determine if packages of care are appropriately planned in advance for end-of-life patients.	Director of Nursing	Q1
Health and Safety	12	SRR010	To complete a review over how key health and safety risks are managed in accordance with the Health Board's policies and procedures, including RIDDOR reporting relating to falls.	Director of Therapies and Health Science	Q4
Waiting List Management	13	SRR005	To review the arrangements in place to reduce the patient waiting lists of services not reported at a national level.	Chief Operating Officer	Q4
Partnership Arrangements	14	SRR001e	To review the processes and procedures that the Health Board has in place to manage its partnership arrangements.	Director of Strategy, Planning and Partnerships / Director of Public Health and Strategic Partnerships	Q1

Planned output	Audit Ref	Strategic Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Medical Equipment and Devices	15		To assess the implementation of the electronic tagging and tracking of medical equipment and devices across the Health Board.	Director of Therapies and Health Science	Q3
Records Management	16		To assess the implementation of the recommendations raised within the 2022/23 internal audit.	Director of Digital / Chief Operating Officer	Q2
Job Planning	17		To provide assurance that arrangements are in place and operating effectively for consultant job planning.	Medical Director	Q4
Staff Culture	18	SRR008	A review of the actions underway to influence change following on from the NHS Wales Staff Survey results.	Director of Workforce and OD	Q3
Medical E-Rostering	19	SRR005	To provide an opinion over the processes for the implementation of the roll-out plan for the management of medical e-rostering.	Medical Director / Director of Workforce and OD	Q2
Follow-up of High Priority Recommendations	20		To assess whether high priority internal audit recommendations have been implemented.	Director of Corporate Governance	Q4

Planned output	Audit Ref	Strategic Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Welsh Intensive Care System	21	SRR006	A review of the arrangements in place for implementing the Welsh Intensive Care System.	Director of Digital	Q1
Analytics and Information Use	22	SRR006	To evaluate and determine the processes in place to deliver information products to staff and maximise the use of analytics in an appropriate and secure manner.	Director of Digital	Q2
Technical Continuity	23	SRR004	Review of the enactment of technical resilience and awareness of fault domains to ensure the Health Board is maximising the potential for resilience within the architecture.	Director of Digital	Q3
Electronic document and records management solution	24		An opinion over the effectiveness and appropriateness of the electronic document and records management solution (EDRMS) in use for the management of digital health records and the provision of scanning services.	Director of Digital	Q4
Capital Systems/Major Project Provisions (not separately provided)	25		Having been omitted from internal audit plans in recent years, it is proposed to reintroduce periodic capital systems audits. These audits review the control framework, systems and processes in place to manage	Director of Strategy, Planning and Partnerships	Q3

Planned output	Audit Ref	Strategic Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
			discretionary, EFAB or other capital/ estates funded schemes (not progressed through integrated audit plans (IAP) – ensuring compliance with minimum requirements. The focus of the audit for 2024/25 may include: • initial governance arrangements, • tendering and/or selection, and • approval to award and contract completion.		
Nevill Hall RAAC	26	SRR002 SRR002a	The review will focus on the works to manage and address the Reinforced Autoclave Aerated Concrete (RAAC) identified within Nevill Hall General Hospital.	Chief Operating Officer	Q1
Estates Assurance – Energy Management	27		Recognising the increase in utility costs and the associated financial risks, the audit will examine the arrangements in place to manage energy consumption, optimisation, conservation and efficiency. The audit will look to gain assurance the	Chief Operating Officer / Director of Finance, Procurement and Value	Q4

Planned output	Audit Ref	Strategic Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
			appropriate arrangements are in place to gather data, ensuring that the data is of suitable quality/ reliability. The audit will also look at resulting strategies and/ or plans to address key risks.		
Integrated Audit & Assurance Plans					
Development of Integrated Audit Plans	N/A		In accordance with the NHS Wales Infrastructure Investment Guidance (2018), Audit will work with the UHB to "assess the risk profile of the scheme and provide appropriate levels of review". A small provision of days is included within the 2024/25 plan to enable us to work with the UHB to develop audit plans for inclusion within the respective business case submissions for major projects/ programmes.		

Please note: Capital audits agreed with our specialist Capital & Estates Team and the national audits undertaken at DHCW, NWSSP, WHSSC and EASC will be added later.

* refers to audit work being completed across other NHS Wales organisations.

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2024/25
Audit plan 2024/25 agreed/in draft by 30 April	⚑	100%
Draft audit opinion 2023/24 delivered by 31 May	⚑	100%
Audits reported versus total planned audits, and in line with Audit, Risk and Assurance Committee expectations	⚑	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 days]	⚑	95%
Report turnaround management response to draft report [15 working days]	⚑	80%
Report turnaround draft response to final reporting [10 days]	⚑	95%

Appendix C: Internal Audit Charter

1 Introduction

1.1 This Charter is produced and updated annually to comply with the Public Sector Internal Audit Standards. The Charter is complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Charter:

- Board means the Board of Aneurin Bevan University Health Board with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit, Risk and Assurance Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for Aneurin Bevan University Health Board. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Director of Corporate Governance.

1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measure 2011. We are happy to correspond in both Welsh and English.

2 Purpose and responsibility

2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of Aneurin Bevan University Health Board. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit, Risk and Assurance Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.

2.3 The organisation's risk management, internal control and governance

arrangements comprise:

- the policies, procedures and operations established by the organisation to ensure the achievement of objectives;
- the appropriate assessment and management of risk, and the related system of assurance;
- the arrangements to monitor performance and secure value for money in the use of resources;
- the reliability of internal and external reporting and accountability processes and the safeguarding of assets;
- compliance with applicable laws and regulations; and
- compliance with the behavioural and ethical standards set out for the organisation.

2.4 Internal audit also provides an independent and objective consulting service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such consulting work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

3.1 Independence as described in the Public Sector Internal Audit Standards as the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit, Risk and Assurance Committee and Accountable Officer.

3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit, Finance and Risk Committee on behalf of the Board. Such functional reporting includes the Audit, Risk and Assurance Committee:

- approving the internal audit charter;
- approving the risk based internal audit plan;
- approving the internal audit resource plan;
- receiving outcomes of all internal audit work together with the assurance rating; and

- reporting on internal audit activity's performance relative to its plan.

3.3 While maintaining effective liaison and communication with the organisation, as provided in this Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.

3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited.

3.5 This Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.

3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Standards that apply to non-audit activities.

4 Authority and Accountability

4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit, Risk and Assurance Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.

4.2 The Minister for Health and Social Services has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.

4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Public Sector Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.

4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit, Risk and Assurance Committee on behalf of the Board. Accordingly, the Head of Internal Audit has a direct right of access to the Accountable Officer, the Chair of the

Audit, Risk and Assurance Committee and the Chair of the organisation if deemed necessary.

4.5 The Audit, Risk and Assurance Committee approves all Internal Audit plans and may review any aspect of its work. The Audit, Risk and Assurance Committee also has regular private meetings with the Head of Internal Audit.

4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any committee or sub-committee of the Board charged with aspects of governance.

5 Relationships

5.1 In terms of normal business the Accountable Officer has determined that the Director of Corporate Governance will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.

5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Director of Corporate Governance in planning its work programme.

5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.

5.4 Internal Audit will meet regularly with the external auditor, Audit Wales, to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. In particular, Internal Audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.

5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.

5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, such as the Digital Health and Care Wales, NHS Wales Shared Services Partnership, WHSSC and EASC.

5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two-way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.

5.8 The Audit, Risk and Assurance Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit, Risk and Assurance Committee will remain the final reporting line for all our audit and consulting reports.

6 Standards, Ethics, and Performance

6.1 Internal Audit must comply with the Definition of Internal Auditing, the Core Principles, Public Sector Internal Audit Standards and the professional Code of Ethics, as published on the NHS Wales e-governance website.

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2021) and associated performance standards agreed with the Audit, Risk and Assurance Committee and the Shared Services Partnership Committee. The Service Level Agreement includes a number of Key Performance Indicators, and we will agree with each Audit Committee which of these they want reported to them and how often.

7 Scope

7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:

- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
- reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
- reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
- reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;
- reviewing operations or programmes to ascertain whether results are consistent with the organisation’s objectives and goals and whether the operations or programmes are being carried out as planned;
- reviewing specific operations at the request of the Audit, Risk and Assurance Committee or management, this may include areas of

concern identified in the corporate risk register;

- monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance;
- ensuring effective co-ordination, as appropriate, with external auditors; and
- reviewing the Annual Governance Statement prepared by senior management.

7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation's risk environment.

7.3 If the Head of Internal Audit or the Audit, Risk and Assurance Committee consider that the level of audit resources or the Charter in any way limit the scope of internal audit or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Charter and Standards, Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 1.

Figure 1: Audit planning hierarchy

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales equirements of the Charter
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives priorities and risk assessment
	Entity annual internal audit plan	Annual internal audit plan detailing audit engagements to be completed in year ahead leading to the overall HIA opinion
Business Unit Level	Assignment plans	Assignment plans detail the scope and objectives for each audit engagement within the annual operational plan

8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by DHCW and NWSSP on behalf of NHS Wales.

8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the assurance needs of the organisation will be met as required by the Standards and facilitate:

- the provision to the Accountable Officer and the Audit, Risk and Assurance Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement;
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation's objectives and risks;
- improvement of the organisation's risk management, control and governance by providing management with constructive recommendations arising from audit work;
- an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan';
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information and outlining the scope and timing of audit assignments to be completed during the year ahead.

8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit, Risk and Assurance Committee on behalf of the Board.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the relevant Executive Director or their nominated lead and will also be copied to the Director of Corporate Governance.

9 Reporting

9.1 Internal Audit will report formally to the Audit, Risk and Assurance Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
- The Head of Internal Audit opinion will:
  a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes;
  b) Disclose any qualification to that opinion, together with the reasons for the qualification;
  c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies;
  d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement;
  e) Compare work actually undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria; and
  f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.
- For each Audit, Risk and Assurance Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit, Risk and Assurance Committee requirements; and

- The Audit, Risk and Assurance Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers to confirm understanding and shape the reporting stage through issue of a discussion draft report;
- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the closure of fieldwork. Operational management will be required to respond to the discussion draft report within 5 working days of issue.
- The discussion draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B (unless it is a consulting review). The discussion draft report will also indicate priority ratings for individual report findings and recommendations;
- Following the receipt of comments on the discussion draft (for factual accuracy etc), operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken;
- Reminder correspondence will be issued to the Executive Director and the Director of Corporate Governance 5 working days prior to the set response date.
- Where management responses are still awaited after the 20 working days deadline, or are of poor quality, the matter will be immediately escalated to the Executive Director and copied to the Director of Corporate Governance and Chair of the Audit, Risk and Assurance Committee.
- If non-compliance continues, the Director of Corporate Governance and the Chair of the Audit, Risk and Assurance Committee will decide on the course of action to take. This may involve the draft report being submitted to the Audit, Risk and Assurance Committee, with the Executive Director being called to the meeting to explain the situation and why no responses/poor responses have been received;
- Internal Audit issues a Final report to Executive Director within 10 working days of receipt of complete management response.

Within this timescale Internal Audit will quality assess the responses, and if necessary return the responses, requiring them to be strengthened.

- Responses to audit recommendations need to be SMART:
  - Specific
  - Measurable
  - Achievable
  - Relevant / Realistic
  - Timely.

- The relevant Executive Director, Director of Corporate Governance and the Chair of the Audit, Risk and Assurance Committee will be copied into any correspondence.
- The final report will be copied to the Accountable Officer and Director of Corporate Governance and placed on the agenda for the next available Audit, Risk and Assurance Committee.

9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow-up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.

9.4 Timescales are to be included in all initial scopes sent prior to commencing an audit.

10 Access and Confidentiality

10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.

10.2 All information obtained during the course of a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access shall be granted to the organisation's external auditors.

10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on

activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.

11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.

11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Public Sector Internal Audit Standards, is being achieved.

12.2 The Director of Audit & Assurance will establish a quality assurance and improvement programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to the Audit, Risk and Assurance Committee.

12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit, Risk and Assurance Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition, any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.

13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Managing Director of Shared Services.

14 Review of the Internal Audit Charter

14.1 This Internal Audit Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit, Risk and Assurance Committee.

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
March 2024

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CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	16 April 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Committee Risk Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide assurance to the Audit, Risk, and Assurance Committee that the strategic risks associated with achieving the Board's strategic priorities are effectively managed.

As well as to provide assurance on the progress being made to mature risk management within the Health Board.

Cefndir / Background

The Audit, Risk, and Assurance Committee's role is to assure the Board that the risk management processes in place are effective in reducing or mitigating the level of risk to the Board's strategic priorities. By receiving this report, the Committee has oversight of the strategic risks and can determine whether the risk management processes, controls, and assurances in place are adequate to mitigate or prevent the risk being realised.

Since the Committee's last meeting in February 2024, changes to the Strategic Register were approved by the Board at its meeting in March 2024.

The Board approved the de-escalation of **SRR 003A and SRR 009** to the Corporate Risk Register, which will be monitored by the Executive Committee. The reduction in score of **SRR 001H** and **SRR 010**, changes to two risk descriptions **SRR 001G and SRR 007A**, as well as the inclusion of a new sub-risk **SRR 001I** as outlined below.

De-escalation from a Strategic to Divisional / Directorate Risk

SRR 003A - There is a risk that the Health Board breaches its duties in respect of safeguarding the needs of children and adults at risk of harm and abuse; *due to limited availability of in-patient facilities and availability of care packages for children and young people, there can be delays in appropriate placements.*

SRR 009 - The Health Board will be unable to protect those most vulnerable to serious disease; d*ue to delays in providing COVID-19 vaccinations as a result of challenges with the recruitment of registered and unregistered immunisers, as changes to the vaccination delivery programme.*

Reduction in Risk Score and Exposure

SRR 001H - There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services which meet the changing needs of the population*; due to the Public Health Directorate being heavily reliant on non-recurrent funding grants.*

SRR 010 - The Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974; *due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed, and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.*

Changes to Sub-Risk Descriptions

The Finance and Performance Committee proposed a change to the sub-risk description for **SRR 001G**, recognising that the risk had presented itself in the form of a failure to meet strategic and operational delivery plans to bring costs down to funded levels.

The Partnerships, Public Health, and Planning Committee proposed a change to the sub-risk description for **SRR 007A** considering the financial landscape impacting the working relationships of strategic public sector partners.

Identification of a New Strategic Sub Risk under SRR 001

SRR 001I 'There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services which meet the changing needs of the population; *due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.*

Asesiad / Assessment

The table below provides an overview of the high-level strategic risks as at end March 2024, with the full Strategic Risk Register (SRR) included at **Appendix A** and detailed risk assessments for the **20** sub-risks included at **Appendix B**.

SRR 003 and **SRR 009** are not included in the table as they are no longer a strategic risk.

Overarching Strategic Risk Description	Number of Sub-Risks	Risk Level		Sub-Risk Theme	Delegated Committee
		High (8 – 12)	Extreme (15 – 25)		
SRR 001 - There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population.	**9 (A-I)**	2	2	People	People and Culture Committee
		*3	1	Service Delivery	Partnerships, Public Health & Planning Committee
		-	1	Financial Sustainability	Finance and Performance Committee
SRR 002 - There is a risk that there will be significant failure of the Health Board's estate.	**2 (A -B)**	1	1	Compliance and Safety	Partnerships, Public Health & Planning Committee
SRR 004 - There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to a major incident, business continuity incident or critical incident.	**1**	-	1	Compliance and Safety	Partnerships, Public Health & Planning Committee
SRR 005 - There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.	**1**	1	-	Service Delivery	Patient Quality, Safety & Outcomes Committee
SRR 006 - There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.	**3 (A – C)**	2	1	Service Delivery	Finance and Performance Committee
SRR 007 - There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	**2 (A – B)**	2	-	Transformation & Partnership Working	Partnerships, Public Health & Planning Committee

SRR 008 - There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.	**1**	-	1	Transformation & Partnership Working	Patient Quality, Safety & Outcomes Committee
SRR 010 - The Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974	**1**	1	-	Compliance and Safety	Patient Quality, Safety & Outcomes Committee
Total	**20**	**12**	**8**		

*Risk assessment SRR 001I is still under development but the initial assessment has determined it to be a high risk (score 8-12)

All **20** sub-risks are sent out to the Lead Director on the 1st of every month aligned to the frequency of the risk score for review and update and are presented to their delegated Committee for focused scrutiny.

Furthermore, work with Executive Directors continues to identify and record any high-level operational risks in the Corporate Risk Register (CRR). These will be risks that require a higher level of ownership than an individual Executive Director can provide and will thus be owned by the Executive Team. In line with the Risk Management Framework's Escalation Process, the risks included in the CRR will typically span two or more divisions or require plans and resources that are beyond the Division's capability or capacity to implement.

Risk Management

Since the Risk Management Framework was approved in January 2024, work to embed the principles and processes across the Health Board has progressed, as evidenced by the Internal Audit review of risk management within the Digital Directorate received at April's Committee meeting.

The purpose of the review was to assess the effectiveness of the Health Board's risk management and assurance arrangements in order to ensure that strategic objectives are met. The review concluded a reasonable assurance outcome and only one medium-rated recommendation, which is concerned with the recording of risks on the electronic risk management system, which has commenced.

The Head of Corporate Risk and Assurance has met with the directorate on several occasions to provide risk management and Datix training. Recording of all risks is underway; directorate risks have been added to Datix, with local department risks to follow.

This approach to maturing the Health Board's risk management will be replicated across all divisions.

Argymhelliad / Recommendation

The Committee is requested to:

- **NOTE** the Strategic Risk Register and Risk Assessments for the 20 sub-risks; and,
- **NOTE** the continued work to mature risk management within the Health Board

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The Corporate Risk Register is informed by Datix, ensuring a bottom-up approach to risk escalation.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Corporate Risk Register assesses risk that could impact achievement of all strategic priorities.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	Explained within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans;

	investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Choose an item.

Risk ID	Monitoring Committee	Risk Theme	Risk Owner	Risk Description	Reason For The Risk	Impact	Current Risk Score				Risk Appetite		Actions to Reduce Risk to Target	Assurance that the Risk is being manged effectively	Target Risk Score				Review of Risk	
							Likelihood Of The Risk Occuring	Impact Of Risk Occuring	Current Risk Score	Risk Level	Current Status Against Appetite	Risk Appetite and Threshold Explained			Likelihood Of The Risk Occuring	Impact Of Risk Occuring	Target Risk Score	Risk Level	Last Reviewed	Next Review
	People & Culture Committee	People	Director of Workforce and Organisational Development		a)Due to an inability to recruit and retain staff across all disciplines and specialities.	•Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with safe staffing principles and standards •Reliance on agency and bank staff •Litigation & Financial Penalties	4	4	16	Extreme	Within Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Staff Attendance: Continuing support for staff who are absent in line with Managing Attendance at Work Policy, including those on long term absence with a view to signposting to self-help support, and adapting/adjusting roles to enable a safe return to work., "Hot spot" areas identified and plans in place to support. Recruitment: Engagement with national recruitment campaigns such as BAPIO, Train, Work, Live and Student Streamlining for Registered Nurses, Physician's Associates, Midwives, and therapy staff and with HEIW for Junior Doctor, Annual programme of Apprentice recruitment, Overseas Nursing (All Wales), Nursing Workforce Strategy, Streamlining and improve recruitment timescales through recruitment modernisation programme (started Oct 22) , Partnerships with employability schemes such as Kickstart and Restart, Actively working with Local Authorities to promote joint recruitment activities and Registration – Temporary register extended for 2 years to enable staff to return to practice. Retention: Development of career pathways (e.g., non-clinical to clinical), Engagement chat cafes providing information and support for key topics such as Agile Working, Learning and Development, Wellbeing Activity, Occupational Health, and Complex HR, Internal Exit interview group has been established with a view to 1) Increase the numbers of people completing the forms and 2) Turn the data into intelligence so that we can understand and respond to organisational and local level impacts, Changes in pension regulation and flexile retirement options from October 23 and reduced break in service required following retire and return, Agency reduction and Plan in place to monitor and review all agency, bank pay incentives supply and demand. E-Systems: Effective deployment of current staff - Programme Plan to introduce Workforce Medical E-Systems to support effective deployment of medical staff, Development of alternative and new roles , Continued implementation of new roles such as Physician Associates, Enhanced and Advanced roles to support workforce skills gaps in line with IMTP, Primary Care workforce The Regional Integrated Fund (RIF) Workforce Programme is in development to support the wider health and social care staffing issues as required in Healthier Wales. and Gwent Workforce Board is being tweaked to support scaling up of initiatives and pace. Training: The HEIW Education & Training Plan continues the investment in education and training in Wales that has been increasing over past years - Adult Nursing (36%) and Mental Health Nursing (20%), Healthcare science, Allied Health Professionals Clinical Psychology (11%- 43%). This will increase the number of graduates coming out of training in 2022 and beyond which are required to support turnover and existing vacancies, HEIW are increasing the capacity of training through creating more spaces for training the future Primary Care workforce. Including Primary Care Academy, Development of Leadership Development programmes for key roles such as the Clinical Director post (CDx) started with 3 cohorts in September 2022 and recruiting the 4th cohort to start Oct 23. Nursing Academy, Leadership Development program (entry level) and Leading People (advanced Level) programs fully booked. Core Leadership prog currently delivering to 200 Staff: Vacancy Numbers and establishment control Quarterly reporting of vacancy numbers for each staff to the WG. Last reporting period March 23 there were circa 728 WTE vacancies and Development of ESR establishments commenced on a national basis w/c 03/09/23.	Medium	3	2	6	Low	01/03/2024	01/04/2024
					b) Due to a deterioration in, and a failure to improve, the well-being of our staff	•High absence levels, with some sustained long periods •Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with safe staffing principles and standards •Reputational damage to the health board as an employer •Work-related industrial injury claims •Moral injury	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Continue to work with other Health Boards and Trust in NHS Wales (recent work with WAST & Powys delivering well-being webinars)., Increase wellbeing initiatives: Implement and progress new Integrated Psychological Well-being roles and peer support networks within divisions and hospital sites, Identify, training and develop Respect and Resolution advocates (similar to Mental Health first aiders), Train Mediators so there is team and organisational resilience and network, Regular Schwartz rounds arranged across the Health Board, Taking Care giving care Rounds integrated into our leadership offers and available for teams to undertake either with support or on their own. Close links with the Arts in Health programme, Promotion of walking meetings in leadership programmes Working with Planning and Estates team to ensure the Queens Canopy is designed to promote clear walking routes for that can be used during breaks for meetings Inclusion of break times and staff rooms in wellbeing survey to audit current provision. Chaplaincy service for staff , Re-launching Chill out in the Chapel, Recruitment of staff counsellors, Establishment of new bilingual Health and Well-being AB Pulse page on the intranet with library of resources for staff well-being , Scope, design and deliver a programme of research 'Healthy Working Day', Enhanced our financial well-being offer. Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate. Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management, Drafting of a 10-year plan focusing on optimising the employee experience of work , The Avoidable Employee Harm Programme was launched on 5th July 2022 initially focusing on HR processes it will then look to other formal processes that inadvertently cause harm to all those involved and the organisation. The training day that supported the launch has evaluated very well and organisations beyond ABUHB are keen to engage. Within ABUHB we have subsequently seen a >60% reduction in gross misconduct investigations. Occupational Health Occupational Health and NWSSP are working in partnership to implement a new Occupational Health Software system across Wales called OPASG2. OPASG2 provides benefits to employment and recruitment processes, Occupational Health and the Well-being Service continue to work with Therapies colleagues on support for staff experiencing Long Covid-19. Reviewed Occupational Health provision and consider options to improve sustainability within the service, paper drafted, Support equality and diversity of workforce Review of staff diversity networks, Review of wellbeing survey through and equality lens to understand variations within diverse workforce demographic profile. Development of a buddy system to assist international medical staff with induction and orientation and support values and current norms.	Medium	3	3	9	Moderate	12/01/2024	12/04/2024

														Development of an empowerment passport to support disabled staff and reasonable adjustments and wellbeing. Other Assessment of compliance against BMA Rest and Facilities charter complete with action plan developed, reporting to LNC, Reducing fatigue poster developed							
					c) Due to insufficient and ineffective leadership levels throughout the organisation.	•Adverse impacts on delivery of care to patients across acute and non-acute settings •Failure to deliver health board priorities, required improvements and achieve sustainability •Poor levels of accountability and delivery •Reputational damage to the health board as an employer •Adverse impacts on staff recruitment and retention	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Talent and Succession Planning lead appointed in July 2023 on a 6-month secondment funded by HEIW to create an organisational talent management framework to enable the organisation to deliberate and consistently attract, identify and develop talent for critical roles across ABUHB Pilot planned for Finance, Occ Health and divisional managers focusing on how to identify critical roles, development sessions on holding career conversations and culminating in a Talent Management Strategy Local management trainee scheme scoped, and project plan created, JDPS created and evaluated. Project team convened. Paused in May 2022 due to lack of funding. 2021/23 HEIW schemes complete. Two HEIW Grads have successfully completed the programme and have secured promotional roles within NHS in Wales; one within the health board and one at Powys, both at Band 7 level 1 x HEIW funded graduate management trainee successfully appointed August 2023 following additional recruitment process. Executive Director of Planning sat on interview panel. Trainee commences scheme 5th September 2023 at HEIW at joins ABUHB Friday 8th September. Development leadership capabilities Designing learning journeys and access to Gwella Leadership journey and programmes mapped and 1 pager flyer designed & on intranet. Exploring Directorate Manager development. CDx Leadership Development for clinical directors completed for 2022/23 with 45 attendees and CDx cohort 2 starts October 23- open for current and aspiring CDs 2022/2024 Academi Wales scheme the Health Board are sharing a graduate with Monmouthshire Council, our Graduate joined the Health Board in March 2023 and is supporting the decarbonisation agenda.	Medium	3	2	6	Low	12/01/2024	12/04/2024
SRR 001				There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population	d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level	•Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with safe staffing principles and standards •Litigation & Financial Penalties •Reputational damage to the health board and loss of public confidence	4	4	16	Extreme	Within Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Services Business continuity plans in place. All Wales training sessions provide by legal and risk to support industrial action. Ensure early identification of mandated Statutory, and core critical clinical services. Trade union provides a list of the categories of employee to which the affected employees belong, figures on the number of employees in each category, figures on the numbers of employees at each workplace, the total number of affected employees. Such information will enable the employer to readily deduce the total number of employees affected, the categories of employee to which they belong, the number of employees concerned in each of those categories, the workplaces at which the employees concerned work and the number of them at each of these workplaces. Reducing impact on patients - Support for early supported discharge prior to industrial action. Trade Unions specifies: (i) whether the union intends the industrial action to be "continuous" or "discontinuous" (14); and (ii) the date on which any of the affected employees will be called on to begin the action (where it is continuous action), or the dates on which any of them will be called on to take part (where it is discontinuous action). Establish WOD hub with emergency planning to stand up as required Ensure early identification of mandated Statutory, and core critical clinical services. Review of business continuity plans Map services and staff provision and impacts of industrial action. Assess variable pay usage in case of work to rule applies. Assess current vacancies. Working with partners in Gwent on a system wide basis. Implementation of business continuity plans. Communication plans. Establish working mechanisms with NWSSP to consider derogations for junior doctors (who are the employer).	Medium	2	4	8	Moderate	01/03/2024	01/04/2024
					e)Due to inadequate strategic plans which	•Increased demand •Increased patient acuity levels •Worsening of health inequalities •Worsening of health outcomes					Below	Open = 16 or below - Willing to consider all potential options subject to continued application	Area plan is being refreshed through the RPB Marmot Region Implementation Plan Population health management – test and learn using segmentation and risk satisfaction							

	Partnerships, Public Health & Planning Committee	Service Delivery	Director of Strategy, Planning and Partnerships.		respond to population health and socio-economic needs	•Worsening of health outcomes •Failure to train teams in multi-morbidity management •Failure to comply with the Wellbeing of Future Generations Act (Wales) •Reputational damage and loss of public confidence	2	4	8	High	Appetite Level	subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	using linked data to target resource. Refresh organisational strategy with a central focus on population health and wellbeing. Action through SEW Regional Collaborative to identify additional service areas where collaboration and networking would support sustainability.	Medium	2	3	6	Low	12/01/2024	12/04/2024
					f) Due to unsustainable service models	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Increased demand •Increased patient acuity levels •Worsening of health inequalities •Worsening of health outcomes •Failure to deliver health board priorities, required improvements and achieve sustainability •Reputational damage and loss of public confidence	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Area plan is being refreshed through the RPB. Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. Review of enhanced local general hospital service models to ensure sustainable quality services. Development of SEW plan for fragile. Review of organisational strategy – to launch Summer 2024.	Medium	2	3	6	Low	12/01/2024	12/04/2024
	Finance & Performance Committee	Financial Sustainability	Director of Finance and Procurement		g) Due to the failure to deliver a sustainable financial position and longer-term financial plan	•Breach of statutory duty to breakeven over 3 years •Instigation of NHS Wales Escalation & Intervention Arrangements •Non – delivery of health board priorities, required improvements and achieve longer-term sustainability •Prioritisation and possible disinvestment in service delivery •Reputational damage and loss of public confidence	5	4	20	Extreme	Above Appetite Level	Cautious = 12 or below - Preference for safe, though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls.	Update performance management framework Assessment of financial control environment within divisions and corporate teams.	Medium	2	4	8	Moderate	01/04/2024	01/05/2024
	Partnerships, Public Health & Planning Committee	Service Delivery	Director of Public Health and Strategic Partnerships		h) Due to the Public Health Directorate being heavily reliant on non-recurrent funding grants.	➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Increased patient acuity levels ➢ Worsening of health inequalities ➢ Worsening of health outcomes ➢ Unable to substantially improve the health of the population ➢ Reputational damage and loss of public confidence ➢ Multi-year CIP calculated on non-recurrent funding ➢ Major grants subject to funding cuts 24/25 ➢ No determined staffing establishment ➢ Possible at-risk TUPE posts ➢ £1.5 million temporary staff funding (RIF + EYP) majority on permanent contracts ➢ Government grants focused on particular risk factors	4	4	16	Extreme	Within Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Business cases being written for PIP to increase core funding to deliver objectives. Through Pip process work towards a funded establishment reduce risks associated with permanent staff being funded through temporary funding which impacts on the ability to plan long term.	Negative	2	3	6	Moderate	01/03/2024	01/04/2024

		Compliance and Safety	Director of Strategy, Planning and Partnerships .		I) Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.	Under development	3	4	12	High	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	Under development	TBC	3	2	6	Low	tbc	tbc
SRR 002	Partnerships, Public Health & Planning Committee	Compliance and Safety	Chief Operating Officer	There is a risk that there will be significant failure of the Health Board's estate	a) Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with Health & Safety legislation •Litigation & Financial Penalties	3	5	15	Extreme	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	At this stage, the controls in place are appropriate and practicable to monitor the issues and prepare medium-term responses in line with the timelines within the expert report.	Medium	1	2	2	Very Low	01/03/2024	01/04/2024
					b) Due to significant levels of backlog maintenance and Structural Impairment	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with Health & Safety legislation •Litigation	3	4	12	High	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	Active estate rationalisation (including leases) is required to reduce estate demands and help prioritise capital spend to reduce backlog maintenance. A water/ventilation engineer to enable all critical ventilation systems to undergo annual validation in accordance with HTM 04/01. Ongoing attempts to recruit to workforce gaps and a new model of Estate Officer also being developed to assist with recruitment and retention of staff in the workforce. Planning function leading a review of capital priorities which may help identify additional funding priority given to backlog maintenance.	Medium	3	2	6	Low	12/01/2024	12/04/2024
SRR 004	Partnerships, Public Health &		Director of Strategy, Planning	There is a risk that the Health Board is unable to respond in a timely, efficient and effective way	a) Due to ineffective and insufficient emergency planning	•Adverse impacts on delivery of care to patients across acute and non-acute settings •Harm or injury to patients and/or staff •Health Board breaches statutory duties under the	3	5	15	Extreme	Above Appetite	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a	Testing programme of business continuity plans. Review of revised Civil Contingency Act anticipated later this year to determine the impact on the Health Board. Improved Engagement with Divisions, Directorates, and service areas to embed contingency planning in the culture of the organisation, Conduct BIAs develop plans, Exercise, review, to mitigate the risks and threats to service delivery. Repository being created on intranet for BC plans to be added by areas for audit, maintenance, review of interdependencies. Joint planning with PH response in response to infection disease and public health incidence. Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP). Embed an alert, activation and escalation pathway that follows the Health Board	Medium	3	3	6	Low	01/03/2024	01/04/2024

SRR 004	Planning Committee		and Partnerships.	efficient and effective way to a major incident, business continuity incident or critical incident	arrangements at a corporate and operational level	•Health Board breaches statutory duties under the Civil Contingencies Act 2004 •Litigation & Financial Penalties •Reputational damage and loss of public confidence	3	5	15	Extreme	Appetite Level	practicably possible. a negligible/low likelihood of occurance of the risk after application of controls.	predefined C3 (Command, control, and Co-Ordination) structure of strategic, tactical, and Operational. Working with ICT to scope how to maintain critical communications during loss of IT linked telephone systems or national power outages. Work with the communication team to improve incident cascade during an event to ensure Health Board wide awareness in a timely manner. Continue to promote awareness in a timely manner. Continue to promote awareness of the requirement for BC across the Health Board. A tabletop BC exercise is planned for the 10th of October 2023. Continuing participation in multi-agency exercises. Programme plan to be developed to address the weaknesses in business continuity planning. Review of revised Civil Contingency Act anticipated later this year to determine the impact on the Health Board. Development of Pandemic Plan.	Medium	2	3	6	Low	01/03/2024	01/04/2024
SRR 005	Patient, Quality, Safety and Outcomes Committee	Service Delivery	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a)Due to inadequate arrangements to support system-wide patient flow	•Avoidable deaths or significant harm •Delays in releasing ambulances from hospital sites back into the community •Delayed discharges from acute and non-acute settings resulting in deteriorating patients •Litigation & Financial Penalties •Reputational damage and loss of public confidence	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Escalation framework – evidence suggesting inconsistent escalation of ambulance position / long waits and rationale. Winter planning – Ahead of winter 23/24 there are a series of meetings which will ensure that tangible / practical plans are put in place to ensure: Focus Processing power Capacity Mental health-focussed flow meeting – implement a MH-focussed daily forum to ensure the flow requirements and risk profile is understood across all MH sites. Build in more impromptu, OoH and site visits to check on processes i.e., patient safety, risk, and performance across the Divisions. Regional flow processes not always supported with neighbouring HBs (Health Board)	Medium	3	3	9	Moderate	01/04/2024	01/07/2024
					a)Due to the full or partial failure of existing digital infrastructure and systems	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Data breaches •Litigation & Financial Penalties •Reputational damage and loss of public confidence	3	5	15	Extreme	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Implement the recommendations from Templar report: • Outline a step by step process of how the proposed risk treatments need to be implemented. This should include the activities to be performed, who is responsible and deadlines for completion. • Complete any outstanding policy and process development, ensuring there is engagement with non ICT teams including the SIRO and board • Ensure ICT disaster recovery policies are complete and refer to any system specific recovery processes. • Ensure non ICT teams are aware of disaster recovery policies and processes and engaged in developing system breach/failure response definition. • Complete a policy and process review after each incident to identify if anything could be improved in detection, resolution or prevention of a cyber security incident. Also, ensure the same is done whenever there are significant system changes. • Develop the policy and processes for identity and access management to ensure that privileged and critical system accounts are reviewed periodically e.g. 6 to 12 months, with other accounts reviewed through joiners/starters, movers and leavers processes. • Investigate circumstances where dedicated devices can be used for critical system access • Consider plans for certification of users and devices and how those certifications can be used. • Consider how to monitor privileged accounts e.g. with additional logs managing not just by exception but random and planned audits • Assess whether MFA can be implemented for privileged user accounts • Review any critical system logs that are created • Update systems or request updates to create additional logs where possible and include creation of logs on user devices in any investigation • Investigate a means of alerting for specific log conditions • Consider collective identification of appropriate tools and working with other OES within NHS Wales to identify appropriate tools.	Medium	2	4	8	Moderate	01/03/2024	01/04/2024

SRR 006	Finance & Performance Committee	Service Delivery	Director of Digital	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery															
					B) Due to an adverse impact on service delivery in the implementation of new digital systems	• Harm or injury to patients and/or staff • Adverse impacts on delivery of care to patients across acute and non-acute settings • Data breaches • Litigation & Financial Penalties • Reputational damage and loss of public confidence	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	• Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee • Assurance activities included in project framework including clinical safety, information governance, health records and cyber security • An overarching Digital Portfolio Progress Group is in place to receive programme updates, manage risk and issue escalations and provide multi-disciplinary assurance over digital projects • Business change work includes a service readiness impact assessment to enable the project team to develop a realistic plan that incorporates service change requirements • Aggregated view of risks and issues available to pick up common themes and impact for early intervention or escalation • Aggregated view of digital Lessons Learned available and lessons are reviewed during project initiation for best chance of success	Medium	2	3	6	Low	07/02/2024	01/04/2024
					c) Due to a failure to develop digital solutions that are sustainable and fit for the future	• Harm or injury to patients and/or staff • Adverse impacts on delivery of care to patients across acute and non-acute settings • Failure to deliver health board priorities, required improvements and achieve sustainability • Reputational damage and loss of public confidence	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	• New governance structures to be put in place by the end of 2023. • Monthly/quarterly Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities • Annual planning processes to include formal DDAT Annual Operational Plan aligned with service priorities identified in IMTP process • New Digital Request processes refresh with senior leadership scrutiny of requests, implementation of new prioritisation process and quarterly reporting to DDAT sub-committee • Automation of request process via 'Seren' the ICT Portal • Portfolio optimisation to ensure the resources of the service are aligned to key priorities	Medium	2	4	8	Moderate	07/02/2024	01/04/2024
					a) Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.	• Unmet patient need resulting in harm • Ineffective use of combined resources • Delayed decision making • Adverse impacts on delivery of care to patients across acute and non-acute settings • Failure to deliver health board priorities, required improvements and achieve longer-term sustainability • Reputational damage and loss of public confidence	2	4	8	Moderate	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	• Governance review of Regional Partnership Board undertaken in August 2023. • Renewed Strategy for strategic partnership Capital in place and revised governance processes. • New Long-Term Strategy for Health Board to focus on Partnership approach. .	Medium	2	2	4	Low	10/01/2024	10/04/2024

SRR 007	Partnerships, Public Health & Planning Committee	Transformation and Partnership Working	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	b) Due to the impact of fragile services across the regional and supra regional geography	Changes of regional flow in an unplanned way Additional demand on UHB workforce to support fragile services Unmet patient need resulting in harm Ineffective use of combined resources Delayed decision making Failure to deliver health board priorities, required improvements and achieve longer-term sustainability Reputational damage and loss of public confidence	3	3	9	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	The southeast Wales health boards have agreed revised joint priorities and working arrangements for regional planning in 2024, following a recent review workshop attended by Chief Executives. The revised priorities / forward work plan includes the following: - • An absolute commitment to delivering on the existing regional programmes of work but with recognition that these need to be 're-baselined' for 2024/25 to ensure there is a continued regional consensus on objectives, outcomes, and planning assumptions. • The need to review the current regional working governance arrangements, to ensure these remain fit for purpose. • The need to further review the indicative list of fragile services for the Southeast region and begin considering the regions response to these. • The need to develop a regional clinical service plan that can articulate what a long-term sustainable secondary care system looks like for Southeast Wales that can then inform local decisions. Discussion to be had at all Wales NHS CEOs and NHE Executive on governance and infrastructure to take forward cross regional planning to be reviewed considering IR and Neonatal work	Reasonable	2	2	4	Low	16/01/2024	16/04/2024
SRR 008	Patient, Quality, Safety and Outcomes Committee	Transformation and Partnership Working	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff, the public and partners	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement	•Adverse impact on patient experience •Failure to deliver health board priorities, required improvements and achieve longer-term sustainability •Reputational damage and loss of public confidence •Failure to deliver Duty of Quality	2	4	8	Moderate	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	• Corporate Engagement Team • Patient Experience and Involvement Strategy- organisational ownership • Person Centred Care (PCC) Surveys via CIVICA • PCC KPI's (support PCC Quality pillar) • 'You said…… we did' public facing information for service areas. • PLO service at GUH • Introduction of PALS Service (Oct 23) • Volunteer Patient Experience Feedback • Collaboration to recruit community listeners to support Dementia Awareness • Digital patient stories to support listening and learning. • Patient Experience and Involvement Strategy • DATIX	Medium	2	2	4	Low	01/04/2024	01/07/2024
SRR 010	Patient, Quality, Safety and	Compliance	Executive Director of Therapies	The Health Board will fail to protect the Health and Safety of staff, patients and	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's	• Unintended physical harm; • Punitive actions from the Health and Safety Executive (HSE); • Increased levels of staff sickness;	3	4	12	High	Above Appetite	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible; a	• Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices. • Health and Safety Policies and Procedures • Dedicated Health and Safety site on ABPULSE • Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999	Negative	2	3	6	Moderate	01/04/2024	01/07/2024

SKR 010	Safety and Outcomes Committee	and Safety	Therapies and Health Science	visitors in line with its duties under the Health and Safety at Work Act 1974	the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	• Loss of estate due to unsafe environments; • Financial implications; • Adverse publicity; and, • Reputational damage	3	4	12	High	Appetite Level	practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'. • Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) • Partial Programme of Health and Safety Monitoring (Active & Reactive) • Corporate and Directorate Health and Safety Risk Register established.	Negative	2	3	6	Moderate	01/04/2024	01/07/2024

Reference				Risk Score Matrix
				2 | 4 | 5 | 6 | 8 | 9 | 10 | 12 | 15 | 16 | 20 | 25
SRR 001	Director of workforce and OD	There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population	a)Due to an inability to recruit and retain staff across all disciplines and specialities.	
			b) Due to a deterioration in, and a failure to improve, the well-being of our staff	
			c) Due to insufficient and ineffective leadership levels throughout the organisation.	
			d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level	
	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board will be unable to deliver and maintain high quality, safe and sustainable services which meet the changing needs of the population.	e) Due to inadequate strategic plans which respond to population health and socio-economic needs	
			f) Due to unsustainable service models	
	Director of Finance and Procurement	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.	g) Due to the failure to deliver a sustainable financial position and longer-term financial plan	
	Director of Public Health & Strategic Partnerships	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services which meet the changing needs of the population.	h) Due to the Public Health Directorate being heavily reliant on non-recurrent funding grants	
	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services which meet the changing needs of the population.	I) Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.	
SRR 002	Chief Operating Officer	There is a risk that there will be significant failure of the Health Board's estate	a) Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	
			b) Due to significant levels of backlog maintenance	
SRR 004	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a major incident, business continuity incident or critical incident	Due to ineffective and insufficient emergency planning arrangements at a corporate and operational level	
SRR 005	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	Due to inadequate arrangements to support system-wide patient flow	
SRR 006	Director of Digital	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery	a) Due to the full or partial failure of existing digital infrastructure and systems	
			b) Due to an adverse impact on service delivery in the implementation of new digital systems	
			c) Due to a failure to develop digital solutions that are sustainable and fit for the future	
SRR 007	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	a) Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.	
			b) Due to the impact of fragile services across the regional and supra regional geography	
SRR 008	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff and the public	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement	
SRR 010	Director of Therapies and Health Science	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	

Assessment of adequacy of assurances	
	POSITIVE = Identified assurances are deemed robust in telling us that the controls in place are working effectively.
	REASONABLE = Identified assurances are deemed adequate in telling us that the controls in place are working effecively, however some gaps have been identified which need to be addressed.
	NEGATIVE = Identified assurances are deemed insufficent in telling us that the conrols in place are working effectively with substantial gaps identified which need to be addressed.

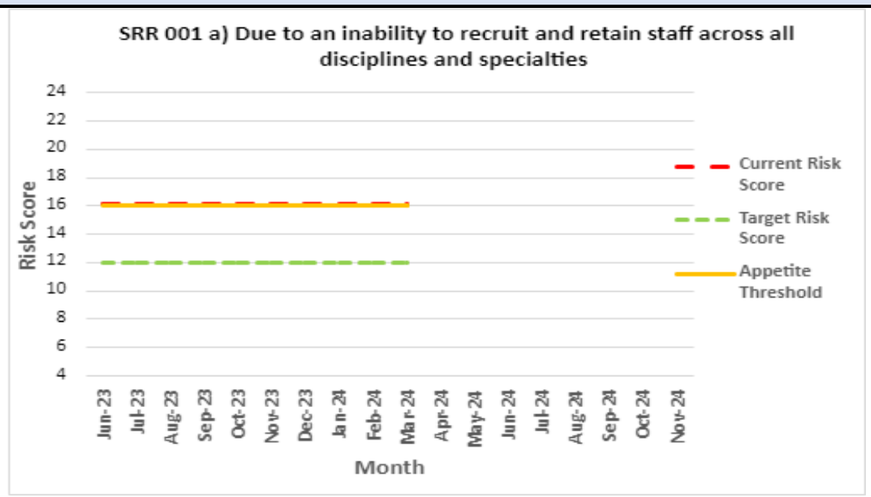
Key	
	Current Score
	Target Score
	Appetite Threshold
	Current to Target

RISK THEME	PEOPLE			
Strategic Risk (SRR 001A)	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			
Strategic Threat	**a)** Due to an inability to recruit and retain staff across all disciplines and specialties.			
Impact	➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Non-compliance with safe staffing principles and standards ➢ Reliance on agency and bank staff ➢ Litigation & Financial Penalties			
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	People & Culture Committee	**Likelihood**	4 *(Likely)* x	3 *(Possible)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	2 *(Minor)*
Last Reviewed	01 March 2024	**Risk rating**	**= 16** *(Extreme)*	**= 6** *(Moderate)*
Next Review	01 April 2024			

Risk Appetite Level – Open
Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold - Score 16 and below
Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.

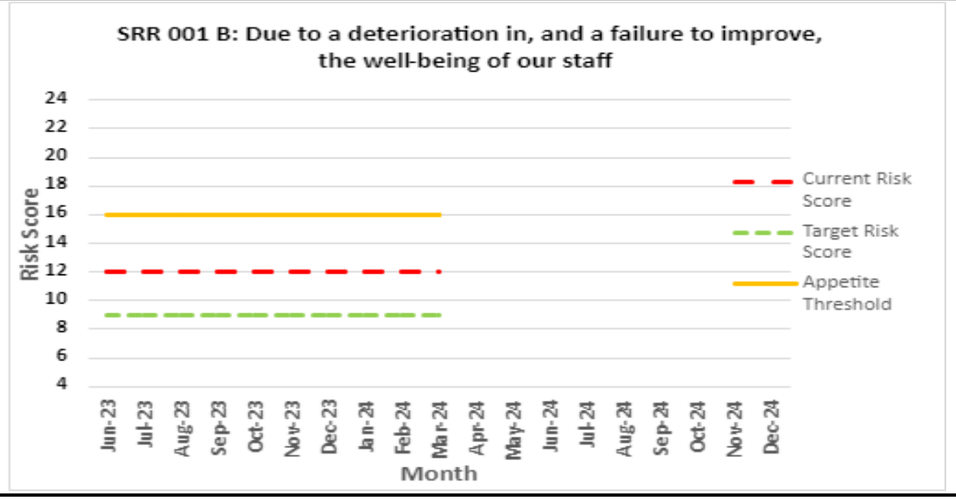
SUMMARY
The current risk level is **outside** of target level and appetite threshold. The target level to be achieved is **within** the set appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Monitoring Framework to support roll-out of the People Plan. • Workforce Dashboard to track activity – recruitment, turnover, sickness absence. • Supply and demand tracker (Nursing and HCSW). • People Plan tracker to support delivery of actions within the People Plan 2022-25. • Variable Pay Reduction Plan approved June 2022 and supported by the Programme Board. • Management of attendance through All Wales Management Attendance at Work Policy. • Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture. • Nurse Staffing Levels (Wales) Act 201625b/25c. • Review of staffing and recruitment plan internally in line with Royal College Guidance, i.e., RCP. • Workforce planning supported by Compendium of new roles to support innovative workforce models. • Recruitment KPI's. • IMTP Educational Commissioning. • Workforce Establishment controls national working group has been instigated.	**Staff attendance** • Continuing support for staff who are absent in line with Managing Attendance at Work Policy, including those on long term absence with a view to signposting to self-help support, and adapting/adjusting roles to enable a safe return to work. • "Hot spot" areas identified and plans in place to support. • **Recruitment** • Engagement with national recruitment campaigns such as BAPIO, M&D Kerela Initiatives, Train, Work, Live and Student Streamlining for Registered Nurses, Physician's Associates, Midwives, and therapy staff and with HEIW for Junior Doctor. • Annual programme of Apprentice recruitment • Overseas Nursing (All Wales Recruitment programme) • Nursing Workforce Strategy agreed • Streamlining and improving recruitment timescales through recruitment modernisation programme (started Oct 22) • Partnerships with employability schemes and FE/HE to widen access. • Actively working with Local Authorities to promote joint recruitment activities via Gwent Workforce Board. • Registration – Temporary register extended for 2 years to enable staff to return to practice ending March 2024. • **Retention:** • Retention lead appointed with programme action plan in place. • Development of career pathways (e.g., non-clinical to clinical).	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Workforce reports to the Nurse Strategic Workforce Group. • Daily sickness monitoring reports. • Weekly filled and unfilled shift reports (RN) and reports of agency for HCSW/RN. • Medical Staffing Co-ordinator review of medical rotas. • Cross site operational calls. • Occupational Health and Wellbeing dashboards report KPIs. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Reports to the People and Culture Committee and the Board on the progress of the People Plan 2022-25 • Workforce Dashboard presented to the Executive Committee, P&CC Committee, and the Board. • Workforce and OD group established to support delivery and implementation of workforce plans to support Clinical Futures Service transformation • Measurements of Wellbeing through the ABUHB Staff Survey.	**Gaps in Assurance** **Action to Address Gaps in Assurance**	**Positive Assurance**

• Value and Sustainability Board.	• Engagement chat cafes providing information and support for key topics such as Agile Working, Learning and Development, Wellbeing Activity, Occupational Health, and Complex HR. • Internal Exit interview group has been established with a view to 1) Increase the numbers of people completing the forms and 2) Turn the data into intelligence so that we can understand and respond to organisational and local level impacts. • Changes in pension regulation and flexile retirement options from October 23 and reduced break in service required following retire and return. • **Variable pay reduction** • Plan in place to monitor and review all agency, bank pay incentives supply and demand reporting to Value and Sustainability Board. • **E- Systems** • Effective deployment of current staff - Programme Plan to introduce Workforce Medical E-Systems to support effective deployment of medical staff. • Utilise benefits of roll out Safe Care staffing to support effective and efficient staff deployment within adult ward areas. • **Development of alternative and new roles** • Continued implementation of new roles such as Physician Associates, Enhanced and Advanced roles to support workforce skills gaps in line with IMTP. • Primary Care workforce The Regional Integrated Fund (RIF) Workforce Programme is in development to support the wider health and social care staffing issues as required in Healthier Wales. Gwent Workforce Board is being tweaked to support scaling up of initiatives and pace. • NCN workforce planning workshops completed Dec 23. An action plan has been developed and to be agreed with PCCS senior management team, NCN board with enabling actions to highlight key challenges and opportunities to support longer term workforce sustainability. • Updating of compendium of new roles and benchmarking is available via workforce planning intranet site and HEIW portal. • Looking to increase assistant band 4 in Community/Mental Health • Continue to extend scope of Advanced Clinical Practitioners to undertake new procedures, reporting etc reducing medical capacity • Increasing consultant therapy and nurse practitioners • Nurses with skills to support chronic disease management in Primary Care • **Training** • The HEIW Education & Training Plan continues the investment in education and training in Wales that has been increasing over past years. In the HEIW Education Training Plan 22/23 there were increases in - Adult Nursing (36%) and Mental Health Nursing (20%), Healthcare science, Allied Health Professionals Clinical Psychology (11%- 43%). This will increase the number of graduates coming out of training in 2024 and beyond which are required to support turnover and existing vacancies. • HEIW are increasing the capacity of training through creating more spaces for training the future Primary Care workforce. Including Primary Care Academy • HEIW have increased Health Care Support Workforce Development funding and there have been further changes for accelerated training pathways in some areas so support entry graduate level qualifications. • RN/HCSW Connect Programme has been established in connection with HEIW and higher education providers to support candidates enter registered nursing training (6 supported this year) • Cadet Nursing programme in place (20 candidates last year) • K102 bridging model now being offered to support HCSW pathways into registered nursing – 10 Mental Health HCSW applied which will address uptake on RMN graduate courses. • Development of Leadership Development programmes for key roles such as the Clinical Director post (CDx) started with 3 cohorts in September 2022 and recruiting the 4th cohort to start Oct 23. Nursing Academy, Leadership Development program (entry level) and Leading People (advanced Level) programs fully booked. Core Leadership prog currently delivering to 200 staff. • Workforce planning within new competency framework commencing Jan 24. • **Vacancy Numbers and establishment control** • Quarterly reporting of vacancy numbers for each staff to the WG. Last reporting period December 24 there were circa 619 WTE vacancies. Reduction 109 WTE from March 23. • Development of ESR establishments commenced on a national basis w/c 03/09/23. Local delivery action plan to be developed for Executive Team approval 25th April 24.	• Routine Reporting against nurse staffing levels. • Variable Pay Programme Board **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • **Internal Audit Reviews 2023 -24** • Long Term Sickness Absence Management (Q4) • Flexible Working (Q4) • • External quarterly vacancy reporting to WG • External reporting on Nursing Staffing Levels • National Acuity Audits (Nursing) • National Workforce Implementation Plan: Addressing NHS Wales Workforce Challenges - The Strategic Workforce Implementation Board will report to the Minister for Health and Social Services with a collective view from a range of key partners including policy and professional leads in WG, and representatives of NHS employers, staff organisations and professional representative.		

RISK THEME	PEOPLE			
Strategic risk (SRR 001B)	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			
Strategic Threat	**b)** Due to a deterioration in, and a failure to improve, the well-being of staff.			**Risk Appetite Level – Open** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.
Impact	➢ High absence levels, with some sustained long periods ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Non-compliance with safe staffing principles and standards ➢ Reputational damage to the health board as an employer ➢ Work-related industrial injury claims ➢ Moral injury			**Risk Appetite Threshold – Open Score 16 and below** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing. **SUMMARY** The current risk level is **outside** of target level but within appetite threshold. The target level to be achieved is **within** the set appetite threshold.
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	People & Culture Committee	**Likelihood**	**3** *(Possible)* *x*	**3** *(Possible)* x
Initial Date of Assessment	01 June 2023	**Impact**	**4** *(Major)*	**3** *(Moderate)*
Last Reviewed	12 January 2024	**Risk rating**	**= 12** *(High)*	**= 9** *(High)*
Next Review Due	12 April 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall)*
• Monitoring Framework to support roll out of the People Plan. • Monitoring delivery of the #peoplefirst project though Executive Team reports, KPI sickness metrics underpinned by People Plan Delivery framework. Engagement ongoing with divisional management teams. • Monitoring of absence, reasons for absence and trends in referrals to Occupational Health and Employee Well-being Service through Workforce Performance Dashboard. • Dashboard reported to Executive Team, TUPF and LNC colleagues and People and Culture Committee with regular summary of Well-being and Occupational Health activity. • Strategic Equality plan • Rest and Facilities charter – monitoring and compliance • Staff related policies.	• Continue to work with other Health Boards and Trust in NHS Wales (recent work with WAST & Powys delivering well-being webinars). • Increase wellbeing initiatives: • Identify, training and develop Respect and Resolution advocates (similar to Mental Health first aiders) • Trained mediators so there is team and organisational resilience and network. • Regular Schwartz rounds arranged across the Health Board • Taking Care giving care Rounds integrated into our leadership offers and available for teams to undertake either with support or on their own. • Close links with the Arts in Health programme • Promotion of walking meetings in leadership programmes Working with Planning and Estates team to ensure the Queens Canopy is designed to promote clear walking routes for that can be used during breaks for meetings Inclusion of break times and staff rooms in wellbeing survey to audit current provision. • Chaplaincy service for staff • Recruitment of staff counsellors • Establishment of new bilingual Health and Well-being AB Pulse page on the intranet with library of resources for staff well-being • Scope, design and deliver a programme of research ‘Healthy Working Day’. • Enhanced our financial well-being offer. • Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate. • Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Monitoring Framework to support roll out of the People Plan 22-25 • Monitoring of demand on wellbeing services • Staff diversity networks • Race/LGBT groups • Wellbeing resources • Occupational Health Service **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • People and Culture Committee reports (People Plan 22-25) • Local wellbeing surveys • LNC – reporting of compliance of BMA Rest and Facilities **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • National workforce surveys • Monitoring and compliance of BMA Rest and Facilities via NHS Employers	**Gaps in Assurance** • Regular meetings with divisions to ensure staff are well supported and staff wellbeing is a priority. **Action to Address Gaps in Assurance** • Meetings with Divisions ongoing.	**Positive Assurance**

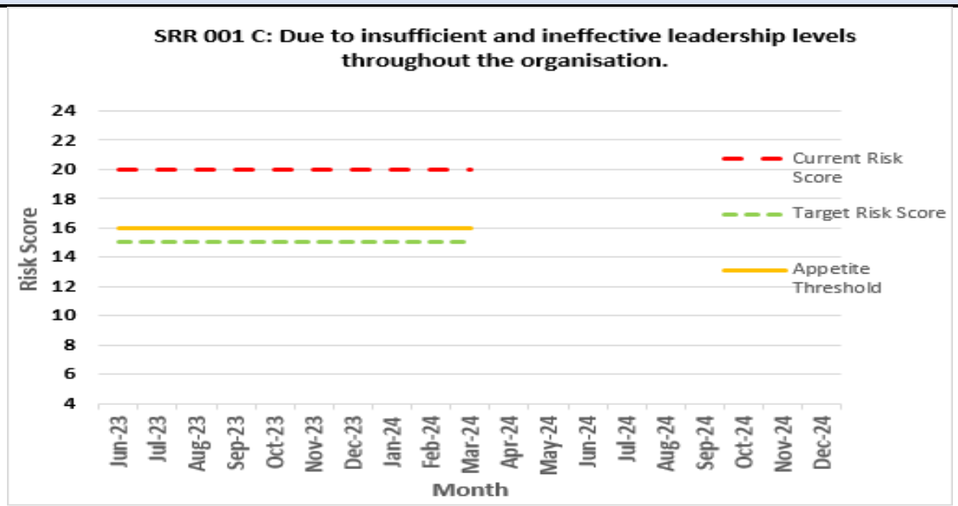
	• The Avoidable Employee Harm Programme, launched on 5th July 2022 initially focusing on HR processes has resulted in a 70% reduction in investigations and a wide range of other organisational benefits. The programme has recently won two NHS Wales awards. • The Avoidable Employee Harm Programme model will be used to underpin our approach to the Speaking up Safely initiative within ABUHB. This workstream began in October 23 and will be developed over the next 12 months with a strong emphasis on evidence analysis and culture. • An external Employee Assistance Programme has been commissioned for 12 months to offer additional psychosocial wellbeing support to staff. **Occupational Health** • Additional occupational health resources secured to reduce waiting times over winter • Occupational Health and NWSSP are working in partnership to implement a new Occupational Health Software system across Wales called OPASG2. OPASG2 provides benefits to employment and recruitment processes. • Occupational Health and the Well-being Service continue to work with Therapies colleagues on support for staff experiencing Long Covid-19. • Reviewed Occupational Health provision and consider options to improve sustainability within the service, paper drafted. **Support equality and diversity of workforce** • Review of staff diversity networks • Review of wellbeing survey through and equality lens to understand variations within diverse workforce demographic profile. • Development of a buddy system to assist international medical staff with induction and orientation and support values and current norms. • Development of an empowerment passport to support disabled staff and reasonable adjustments and wellbeing. • A part time Disability Inclusion Officer has been seconded to the EDI Team (Dec 2023 – Dec 2024). • Recruiting to a Band 5 EDI Officer role (Jan 2024). • Inclusive Leadership sessions to be embedded in the Leading People Programme from Jan 2024 onwards. • Reverse Mentorship Programme to launch Feb 2024. **Other** • Assessment of compliance against BMA Rest and Facilities charter complete with action plan developed, reporting to LNC. • Reducing fatigue poster developed			

RISK THEME	PEOPLE			
Strategic risk (SRR 001C)	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			
Strategic Threat	c) Due to insufficient and ineffective leadership levels throughout the organisation			
Impact	➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Failure to deliver health board priorities, required improvements and achieve sustainability ➢ Poor levels of accountability and delivery ➢ Reputational damage to the health board as an employer ➢ Adverse impacts on staff recruitment and retention			
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	People & Culture Committee	**Likelihood**	**3** *(Possible)* *x*	3 *(Possible)* x
Initial Date of Assessment	01 June 2023	**Impact**	**4** *(Major)*	2 *(Minor)*
Last Reviewed	12 January 2024	**Risk rating**	**= 12** *(High)*	**= 6** *(Moderate)*
Next Review Due	12 April 2024			

Risk Appetite Level – Open
Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold - Score 16 and below
Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.

SUMMARY
The current risk level is **outside** of target level but within appetite threshold. The target level to be achieved is **within** the set appetite threshold.



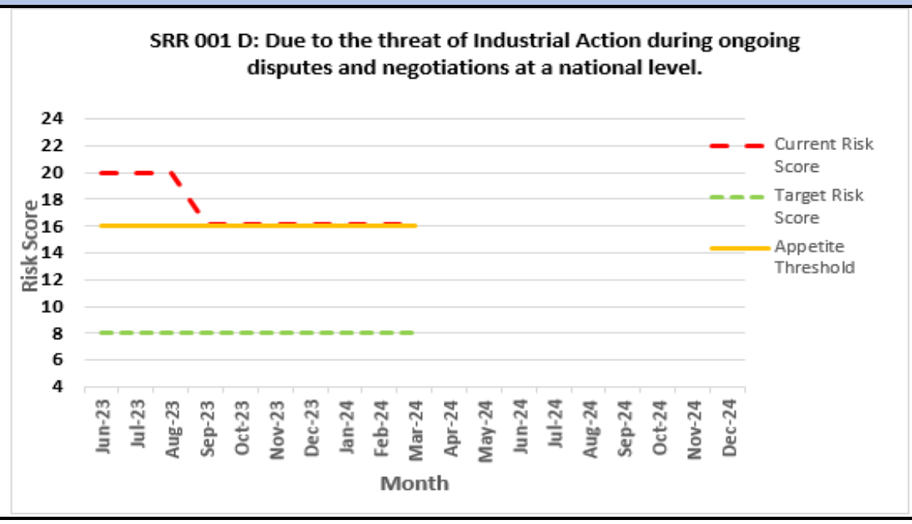
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Monitoring Framework to support roll out of the People Plan- focus on Talent and Succession Planning • Monitoring frameworks with HEIW	**Talent and Succession Planning** • Lead appointed in July 2023 on a secondment funded by HEIW to create an organisational talent management framework to enable the organisation to deliberate and consistently attract, identify and develop talent for critical roles across ABUHB • Pilot planned for Finance, Occ Health and divisional managers focusing on how to identify critical roles, development sessions on holding career conversations and culminating in a Talent Management Strategy • Local management trainee scheme scoped, and project plan created, JDPS created and evaluated. Project team convened. Paused in May 2022 due to lack of funding. • 2021/23 HEIW schemes complete. Two HEIW Grads have successfully completed the programme and have secured promotional roles within NHS in Wales; one within the health board and one at Powys, both at Band 7 level • 1 x HEIW funded graduate management trainee successfully appointed August 2023 following additional recruitment process. Executive Director of Planning sat on interview panel. Trainee commences scheme 5th September 2023 at HEIW at joins ABUHB Friday 8th September. **Development leadership capabilities** • Designing learning journeys and access to Gwella • Leadership journey and programmes mapped and 1 pager flyer designed & on intranet. Exploring Directorate Manager development. • CDx Leadership Development for clinical directors completed for 2022/23 with 45 attendees and CDx cohort 2 starts October 23- open for current and aspiring CDs • 2022/2024 Academi Wales scheme the Health Board are sharing a graduate with Monmouthshire Council, our Graduate joined the Health Board in March 2023 and is supporting the decarbonisation agenda.	Level 1 Operational *(Implemented by the department that performs daily operation activities)* • WOD Divisional reporting • Evaluation of internal leadership programmes Level 2 Organisational *(Executed by risk management and compliance functions.)* • Reporting to People and Culture Committee - progress against People Plan 22-25 **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Internal Audit Review • Talent and Succession Board	**Gaps in Assurance** **Action to Address Gaps in Assurance**	**Positive Assurance**

RISK THEME	PEOPLE			
Strategic Risk (SRR 001D)	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			
Strategic Threat	d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level			
Impact	➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Non-compliance with safe staffing principles and standards ➢ Litigation & Financial Penalties ➢ Reputational damage to the health board and loss of public confidence			
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	People & Culture Committee	**Likelihood**	**4** *(Likely)* x	**2** *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	**4** *(Major)*	**4** *(Major)*
Last Reviewed	01 March 2024	**Risk rating**	**= 16** *(Extreme)*	**= 8** *(High)*
Next Review Due	01 April 2024			

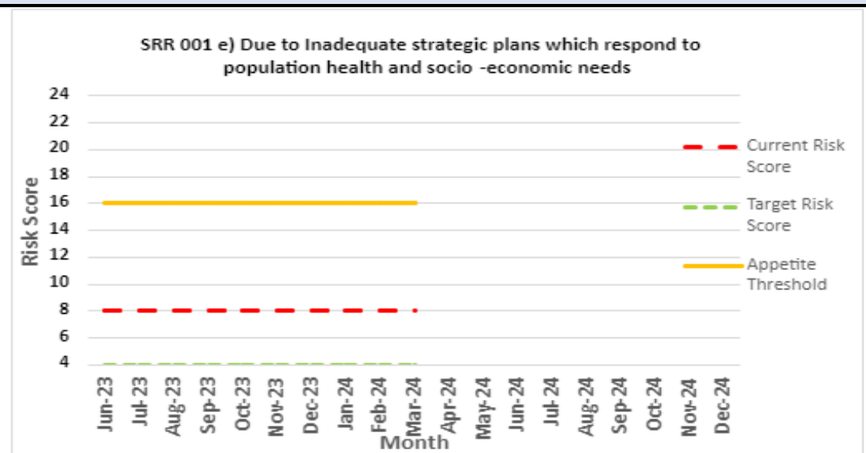
Risk Appetite Level – Open
Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold – Open Score 16 and below
Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.

SUMMARY
The current risk level is **outside** of target level and appetite threshold. The target level to be achieved is **within** the set appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• All Wales Industrial Action Planning Group • Local Health Board planning arrangements • Section 234A of the Trade Union and Labour Relations (Consolidation) Act 1992; and • CODE OF PRACTICE Industrial Action Ballots and Notice to Employers • Business Continuity Processes - Redeployment Principles and Risk Assessment agreed. • Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture.	• Services Business continuity plans in place. • Terms and conditions agreements in place for medical cover supported by NHS Wales Employer guidance • Review of rotas for junior doctor industrial action (minimum staffing levels based on safety assessment). • Command and control structure and leads established • Derogation test completed • Executive and Senior Manager leads established links with national planning cells. • All Wales training sessions provide by legal and risk to support industrial action. • Reducing impact on patients - Support for early supported discharge prior to industrial action. • Communication plans- public, stakeholders and partners • Establish working mechanisms with NWSSP to consider derogations for junior doctors (who are the employer) and pay application • Picketing guidance supported and agreed • Debriefing session planned to reflect and capture learning for any potential future action (national) •	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Local Staff re-deployments assessment • Divisional engagement and service planning arrangements in place • Local Negotiating Committee (LNC) • Trade Union Partnership meetings **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Reporting to Executive team • Business Continuity groups • Command and control structure in place to be implemented as required. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • All Wales IA group and Welsh Government planning cell.	**Gaps in Assurance** • BMA have provided notice of consultant and SAS Dr ballot **Action to Address Gaps in Assurance**	**Reasonable Assurance**

RISK THEME	SERVICE DELIVERY				
Strategic risk (SRR 001)	**There is a risk that the Health Board will be unable to deliver and maintain high quality, safe and sustainable services which meet the changing needs of the population.**				
Strategic Threat	**E) Due to inadequate strategic plans which respond to population health and socio-economic needs.**				**Risk Appetite Level - Open** Willing to consider all potential options, subject to continued application and/or establishment of controls; recognising that there could be a high-risk exposure.
Impact	➢ Increased demand ➢ Increased patient acuity levels ➢ Worsening of health inequalities ➢ Worsening of health outcomes ➢ Failure to train teams in multi-morbidity management ➢ Failure to comply with the Wellbeing of Future Generations Act (Wales) ➢ Reputational damage and loss of public confidence				**Risk Tolerance Level - Open Score 16 and below** Risks relating to all aspects of our ability to deliver, manage and improve service quality and performance along with all relating risks relating to the current performance of our infrastructure such as IM&T and estates including our ability to deliver associated strategy. **SUMMARY** The current risk level is **outside** of target level but within the set appetite threshold.
Lead Director	Director of Strategy, Planning and Partnerships.	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	2 *(Unlikely)*	2 *(Unlikely)* x	
Initial Date of Assessment	01 June 2023	**Impact**	4 (*Major)*	3 *(Moderate)*	
Last Reviewed	12 January 2024	**Risk rating**	**= 8** *(High)*	**= 6** *(Moderate)*	
Next Review Due	12 April 2024				

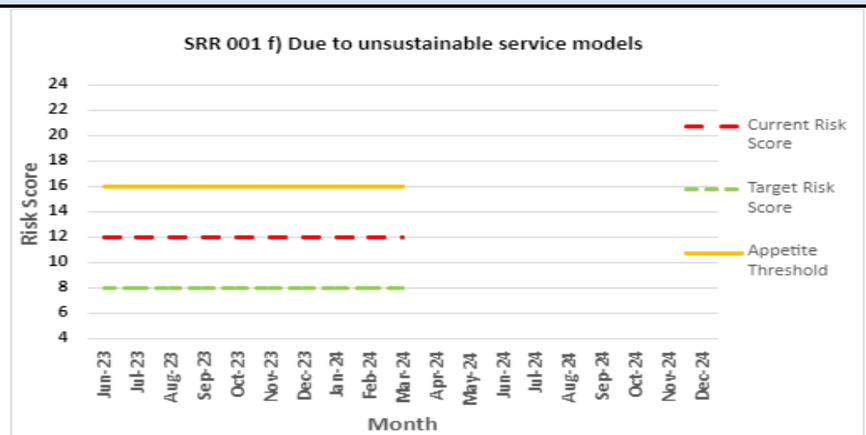
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Health Board IMTP and associated KPIs • Public Health Wales surveillance data • Qliksense – performance dashboard • Population Needs Assessment and Area Plan • Marmot Region Programme	• Area plan is being refreshed through the RPB • Marmot Region Implementation Plan • Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. • Refresh organisational strategy with a central focus on population health and wellbeing. • Action through SEW Regional Collaborative to identify additional service areas where collaboration and networking would support sustainability.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Qliksense – performance information • SFN – performance information **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • IMTP Delivery and Outcomes Reporting to Board • Marmot Region Programme • RPB reporting to Board and Population Health, Planning and Partnerships Committee • Regional Planning reporting to Population Health, Planning and Partnerships Committee • Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* Internal Audit Reviews 2023-24 1. IMTP Planning (Q1) Outcome – Reasonable Assurance	**Gaps in Assurance** • Under review **Action to Address Gaps in Assurance**	**Reasonable Assurance**

RISK THEME	SERVICE DELIVERY			
Strategic risk (SRR 001)	**There is a risk that the Health Board will be unable to deliver and maintain high quality, safe and sustainable services which meet the changing needs of the population.**			
Strategic Threat	**F) Due to unsustainable service models**			
Impact	➢ Harm or injury to patients and/or staff ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Increased demand ➢ Increased patient acuity levels ➢ Worsening of health inequalities ➢ Worsening of health outcomes ➢ Failure to deliver health board priorities, required improvements and achieve sustainability ➢ Reputational damage and loss of public confidence			
Lead Director	Director of Strategy, Planning and Partnerships.	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	4 *(Major)*
Last Reviewed	12 January 2024	**Risk rating**	**= 12** *(High)*	**= 8** *(Moderate)*
Next Review Due	12 April 2024			

Risk Appetite Level - Open
Willing to consider all potential options, subject to continued application and/or establishment of controls; recognising that there could be a high-risk exposure.

Risk Tolerance Level - Open Score 16 and below
Risks relating to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and estates including our ability to deliver associated strategy.

SUMMARY
The current risk level is **outside** of target level but within appetite threshold.



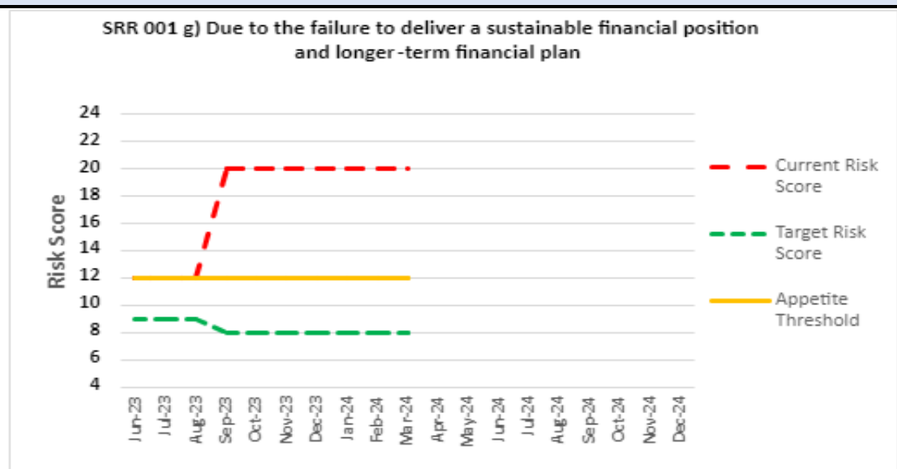
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• The Health Board IMPT and associated KPIs • Clinical Futures Transformation programmes. • Public Health Wales surveillance data – Covid, flu and other communicable diseases. • Qliksense – performance information. • Population needs assessment and area plan development by the RPB. • Southeast Wales Plan for fragile services.	• Area plan is being refreshed through the RPB. • Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. • Review of enhanced local general hospital service models to ensure sustainable quality services. • Development of SEW plan for fragile. • Review of organisational strategy – to launch Summer 2024.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Public Health Wales surveillance data – COVID, flu and other communicable diseases. • Qliksense – performance information. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • IMTP delivery and outcomes reporting to Board. • RPB reporting to Board and Population Health, Planning and Partnerships Committee. • Regional Planning reporting to Population Health, Planning and Partnerships Committee. • Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Internal Audit Reviews 2023-24 1. IMTP planning Q1 Outcome – Reasonable Assurance.	**Gaps in Assurance** • Under review **Action to Address Gaps in Assurance**	**Reasonable Assurance**

RISK THEME	FINANCIAL SUSTAINABILITY			
Strategic Risk (SRR 001)	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			
Strategic Threat	**G) Due to the failure to deliver a sustainable financial position and longer-term financial plan**			
Impact	➢ Breach of statutory duty to breakeven over 3 years. ➢ Instigation of NHS Wales Escalation & Intervention Arrangements. ➢ Non–delivery of health board priorities, required improvements, and achieving longer-term sustainability. ➢ Prioritisation and possible disinvestment in service delivery. ➢ Reputational damage and loss of public confidence			
Lead Director	Director of Finance and Procurement	**Risk Exposure**	**Current Level**	**Target**
Monitoring Committee	Finance & Performance Committee	**Likelihood**	5 *(Almost certain)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	4 *(Major)*
Last Reviewed	08 Feb 2024	**Risk rating**	**= 20** *(Extreme)*	**= 8** *(Moderate)*
Next Review	01 April 2024			

Risk Appetite Level - Cautious.
Preference for safe, through accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls.

Risk Appetite Threshold - Score 12 and below
Risks relating to all aspects of our financial performance and our ability to manage cost and efficiencies.

SUMMARY
the current risk level is **outside** of the target and appetite threshold. The target level to be achieved is **within** the set appetite threshold.



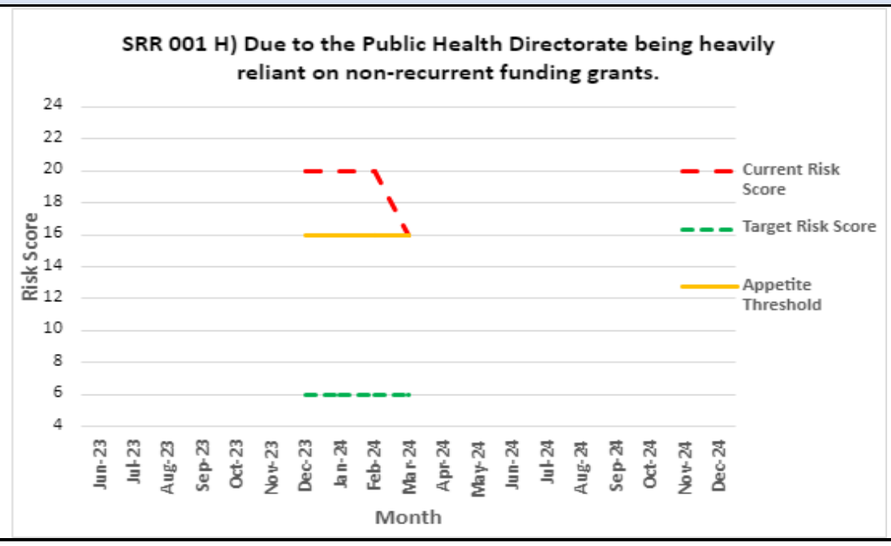
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• IMTP 2023/24-25/26 • IMTP Delivery Framework • Accountability Framework • Performance Framework • Scheme of Delegation • Standing Financial Instructions (SFIs) • Standing Orders (SOs) • Financial Control Procedure (FCP) Budgetary control • Financial Budget Intelligence (FBI) • Budget holder training • Cost intervention procedures • 23/24 savings plans & opportunities. • Health Board financial escalation processes. • Health Board Pre-Investment Panel (PIP) process. • Financial assessment and review to incorporate the financial impact of COVID-19 and other key costs. • Quarterly financial budget plan approach agreed. • Executive groups and structures established to deliver statutory duties	• Update performance management framework – in place • Assessment of financial control environment within divisions and corporate teams. – in place • Financial Escalation Meetings – in place • Regular organisational Recovery plan meetings and briefings • Value & Sustainability Board established	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Adherence to SO/SFI/FCPs • Regular AFD meetings to discuss position and performance. • Divisional Assurance meetings are in place to implement savings plans and deliver service and workforce plans within available resources – part of Chief Operating Officer governance. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular monitoring at the Executive Team reviewing the level of deliverable recurrent savings along with assessing cost avoidance and deferred investments. • Performance escalation meetings established. • Financial assessment and review report to the Board and Finance & Performance Committee • Financial Governance and Accounting reports to the Audit, Risk and Assurance Committee. • Board Briefing sessions on the financial position. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* **Internal Audit Reviews 2023 - 24** 1. Savings Programmes Q3 - Not yet undertaken. Report expected Q1 2024/25 2. Financial Controls Q2 – Not yet reported. Report expected Q4 2023/24 3. Asset Management Q3 – Report to be received at ARAC 08/02/24. **External Audit Reports 2023 -24** 1. Efficiency Review Q3/Q4 – Not yet reported. 2. Structured Assessment - Received at ARAC November 2023. 3. Audit of Financial Statements Q4 2023/24 – Not yet reported. • Financial assessment and review reports to Welsh Government – monthly • Enhanced monitoring meetings with Welsh Government – monthly	**Gaps in Assurance** • Greater focus is required on service, workforce, and financial plans all balancing to achieve financial sustainability. **Action to Address Gaps in Assurance** • Revise accountability arrangements being progressed as part of Executive governance. – in place • 2024/25 IMTP plans focussed on 'living within budget levels' – currently work in progress.	**Reasonable Assurance**

RISK THEME	SERVICE DELIVERY			
Strategic Risk (SRR 001H)	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services which meet the changing needs of the population.**			
Strategic Threat	h) Due to the Public Health Directorate being heavily reliant on non-recurrent funding grants.			
Impact	➢ Avoidable harm ➢ Adverse impacts on the delivery of care to patients across acute and non-acute settings ➢ Increased patient acuity levels ➢ Worsening health inequalities ➢ Worsening health outcomes ➢ Unable to substantially improve the health of the population. ➢ Reputational damage and loss of public confidence ➢ Multi-year CIP calculated on non-recurrent funding. ➢ No determined staffing establishment ➢ Possible at-risk TUPE posts ➢ £1.5 million temporary staff funding (RIF + EYP) majority on permanent contracts ➢ Government grants focused on particular risk factors			
Lead Director	Director of Public Health & Strategic Partnerships	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Partnerships, Population Health, and Planning Committee	**Likelihood**	**4** *(Likely)* *x*	**2** *(Unlikely)* *x*
Initial Date of Assessment	01 December 2023	**Impact**	**4** *(Major)*	**3** *(Moderate)*
Last Reviewed	18 March 2024	**Risk rating**	**= 16** *(Extreme)*	**= 6** *(Moderate)*
Next Review Due	18 April 2024			

Risk Appetite Level – OPEN
Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure**.**

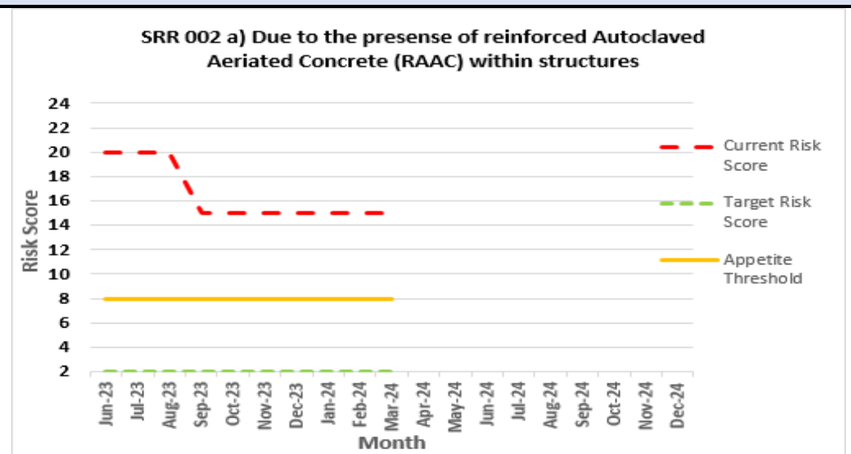
Risk Appetite Threshold – SCORE 16 AND BELOW
Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy

SUMMARY
The current risk level is **outside** of the target level but **within** the set appetite threshold. The target level to be achieved is **within** the set appetite threshold.



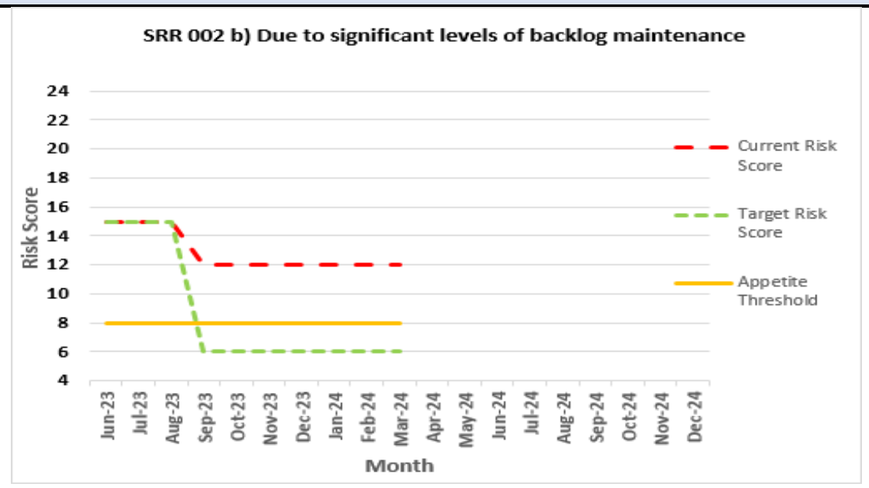
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Organisational Change Process (OCP) instigated which will enable change to the ways of working and moving to a fully funded permanent structure. • Meetings with finance to determine TUPE level and CIP calculation. • Local public health risk register. • Identified risk relating to structure and finance. • Business cases being written for PIP for preventative adverse deaths, Health Protection, and other public health areas. • SMT meetings to discuss progress on delivery of objectives linked to the available budget. • £11.2M recurrent funding has been agreed and received for Health Protection and vaccination. • Work has commenced transferring operational delivery of the vaccination service to Primary Care with oversight from Public Health to ensure effective delivery of programmes (funded by the new recurrent funding from WG to fund Health Protection and vaccination locally)	• Business cases being written for PIP to increase core funding to deliver objectives. • Through the PIP process work towards a funded establishment to reduce risks associated with permanent staff being funded through temporary funding which impacts the ability to plan long-term. • Establish a Health Protection offer within the core Public Health Team to do strategic planning and mitigation and assurance around vaccination delivery.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Monthly finance meetings in place with the Director and Assistant Director • Monthly reporting on finance levels **Level 2 Organisational** *(Executed by risk management and compliance functions)* • Escalation to the Strategic Risk Register for Board oversight • Highlighted and discussed at Corporate Review **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies)* • Report delivery of local progress against the national public health strategy through Public Health Peer Group	**Gaps in Assurance** • Unable to assess the full impact of gaps in delivering the Public Health offer against the prevention agenda **Action to Address Gaps in Assurance** • Through the OCP process we will be able to establish the appropriate areas to place Public Health business for efficient and effective health protection and vaccination delivery. • Developing a clear evidence base to understand population need for long-term public health planning.	**Negative Assurance**

RISK THEME	COMPLIANCE AND SAFETY			
Strategic Risk (SRR 002)	**There is a risk that there will be significant failure of the Health Boards Estates.**			
Strategic Threat	**a)** Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures.			**Risk Appetite Level - MINIMAL** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.
Impact	➢ Harm or injury to patients and/or staff. ➢ Adverse impacts on the delivery of care to patients across acute and non-acute settings. ➢ Non-compliance with health and safety legislation. ➢ Litigation and financial penalties			**Risk Appetite Threshold - SCORE 8 AND BELOW** Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications. **SUMMARY** The current risk level is **outside** of the target level and appetite threshold. The target level to be achieved is **within** the set appetite threshold
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	3 *(Possible)* x	1 (*Rare*) x
Initial Date of Assessment	01 June 2023	**Impact**	5 *(Catastrophic)*	2 *(Minor)*
Last Reviewed	12th January 2024	**Risk rating**	**= 15** *(Extreme)*	**= 2** *(Low)*
Next Review Due	12th February 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Work to assess the risk has been undertaken with expert external surveyor advice and repeat surveys have recently been completed. • Current measures including props and additional support have been put in place in line with the latest guidance and learning from other organisations working through RAAC issues. Plans will be modified in line with any further guidance. • Remediation work to areas of high-risk areas	• Additional Surveys are to take place with expert surveyors to inform the next steps relating to further remediation of the issues.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Fortnightly checks in place for the props in place and will be reduced to fortnightly as the frequency of checks is not demonstrated to be of benefit or required. • Ongoing engagement with expert surveyor and monitoring of RAAC with additional surveys continuing. • The estate's function has controlled access to roof areas and has developed and implemented toolbox talks for awareness for estate teams and contractors to work in those areas. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Estates and Facilities Divisional Compliance team engaged in supporting the estate's function response to the ongoing management. • Health Board Fire and Health and Safety function engaged in fortnightly governance group to monitor risks and issues associated with any remedial measures implemented. • Risk assessments completed by the Health and Safety function in those departments with props to manage any consequences of the presence of props. Note: H&S assessments were around the location of props not of RAAC itself and they flagged no issues or alterations. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Weekly dialogue with Welsh Government and Shared Services Estates. • Links with NHS England and other Health Boards in Wales for shared learning.	**Gaps in Assurance** • Ongoing management of the issues. **Action to Address Gaps in Assurance** • Repeat surveys have been completed and additional more specific and technical surveys have been commissioned and will be undertaken as promptly as possible through the contractor to provide assurance on the work to date as well as determine further management of the risk/issues.	**Reasonable Assurance**

		• Ongoing engagement of external surveyors for regular monitoring of the situation in line with recommended timelines.		

RISK THEME	COMPLIANCE AND SAFETY				
Strategic Risk (SRR 002)	**There is a risk that there will be a significant failure of the Health Board Estates.**				
Strategic Threat	B) **Due to significant levels of backlog maintenance and structural impairment.**				**Risk Appetite Level – MINIMAL** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.
Impact	➢ Harm or injury to patients and/or staff. ➢ Adverse impacts on the delivery of care to patients across acute and non-acute settings. ➢ Non-compliance with health and safety legislation. ➢ Litigation and financial penalties.				**Risk Appetite Threshold – SCORE 8 AND BELOW** Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.
					SUMMARY The current risk level is **outside** of the target level and appetite threshold. The target level to be achieved is **within** the set appetite threshold.
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	Partnerships, Health Protection & Planning Committee	**Likelihood**	3 *(Possible)* x	3 *(Possible)* x	
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	**2** *(Minor)*	
Last Reviewed	12 January 2024	**Risk rating**	**= 12** *(High)*	**= 6** *(Moderate)*	
Next Review Due	12 April 2024				

Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Health Board Estates Rationalisation Strategy • Health Board Estates Strategy • Health Board policies and procedures related to the maintenance of Health Board estate. • 6 Facet survey completed in 2019. • Divisional Risk Register • Multiple policies and SOPs published and communicated to staff. • A robust internal training programme in place covering all aspects of estate management including food hygiene. • Asbestos reinspection programme (over the next 3 years)	• Active estate rationalisation (including leases) is required to reduce estate demands and help prioritise capital spend to reduce backlog maintenance. • A water/ventilation engineer to enable all critical ventilation systems to undergo annual validation in accordance with HTM 04/01. • Ongoing attempts to recruit to workforce gaps and a new model of Estate Officer also being developed to assist with recruitment and retention of staff in the workforce. • Planning function leading a review of capital priorities which may help identify additional funding priority given to backlog maintenance. • Policies being reviewed and priority given to out-of-date policies, but all policies will be reviewed for effectiveness and compliance with HTM. • Drive clinical service engagement in compliance meetings where engagement is low. • Additional escalation for capital funding by the Division Estates and Facilities to support the prevention of seasonal issues and plant failure if possible.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Estates and Facilities division improved statutory compliance processes and forum led by Designated Person - DP (Divisional Director) • Divisional reporting of Statutory and Mandatory training of staff • Staff training levels are monitored and reported regularly. If areas of non-compliance are noted, targeted training can be resourced to ensure compliance. • The divisional risk register is reviewed quarterly by the Senior Management Board this is reported to the Quality & Patient Safety Operational Group. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Outcome of the Asbestos reinspection programme • Regular reporting on estate condition to the Executive Committee and Partnerships, Health Protection & Planning Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* **Internal Audit Reviews 2023- 24** 1. Estates Assurance - Estate Condition audit completed and will be with Audit Committee in February • Authorising Engineer (Shared Service Estates) reports in line with normal timelines, but active engagement with AEs through compliance processes.	**Gaps in Assurance** • AE reports have shown a deterioration in ratings last year. • Membership of HB-wide compliance groups continues to be extended providing wider HB intelligence of the issues. **Action to Address Gaps in Assurance** • The Divisional Director (and DP) has implemented a clear approach to compliance monitoring and escalation of AE reports. • HB-wide groups on compliance (such as Ventilation and water) are being widened in membership to ensure clinical services are active participants.	**Reasonable Assurance**

		• Health Board contributes to annual Estates Facilities and Performance Managements (EFPMS) at all Wales level		

RISK THEME	COMPLIANCE AND SAFETY			
Strategic Risk (SRR 002)	**There is a risk that there will be significant failure of the Health Boards Estates.**			
Strategic Threat	**b)** Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures.			**Risk Appetite Level - MINIMAL** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.
Impact	➢ Harm or injury to patients and/or staff. ➢ Adverse impacts on the delivery of care to patients across acute and non-acute settings. ➢ Non-compliance with health and safety legislation. ➢ Litigation and financial penalties			**Risk Appetite Threshold - SCORE 8 AND BELOW** Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications. **SUMMARY** The current risk level is **outside** of the target level and appetite threshold. The target level to be achieved is **within** the set appetite threshold
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	3 *(Possible)* x	1 (*Rare*) x
Initial Date of Assessment	01 June 2023	**Impact**	5 *(Catastrophic)*	2 *(Minor)*
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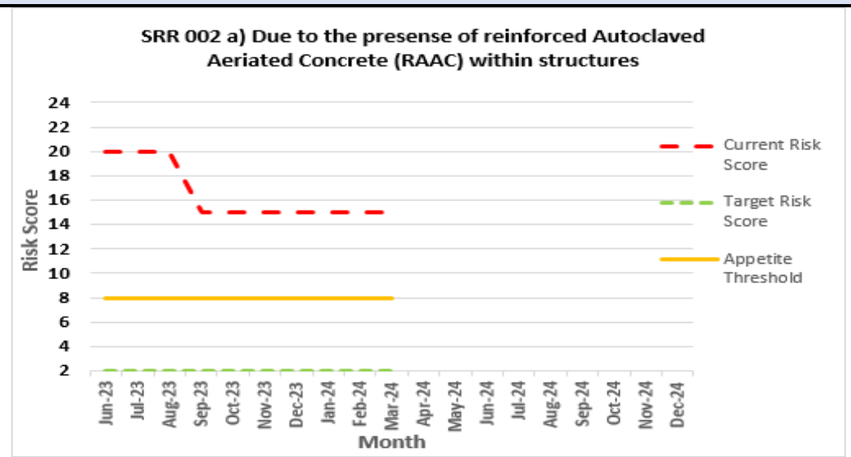

Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Work to assess the risk has been undertaken with expert external surveyor advice and repeat surveys have recently been completed. • Current measures including props and additional support have been put in place in line with the latest guidance and learning from other organisations working through RAAC issues. Plans will be modified in line with any further guidance. • Remediation work to areas of high-risk areas	• Additional Surveys are to take place with expert surveyors to inform the next steps relating to further remediation of the issues.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Fortnightly checks in place for the props in place and will be reduced to fortnightly as the frequency of checks is not demonstrated to be of benefit or required. • Ongoing engagement with expert surveyor and monitoring of RAAC with additional surveys continuing. • The estate's function has controlled access to roof areas and has developed and implemented toolbox talks for awareness for estate teams and contractors to work in those areas. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Estates and Facilities Divisional Compliance team engaged in supporting the estate's function response to the ongoing management. • Health Board Fire and Health and Safety function engaged in fortnightly governance group to monitor risks and issues associated with any remedial measures implemented. • Risk assessments completed by the Health and Safety function in those departments with props to manage any consequences of the presence of props. Note: H&S assessments were around the location of props not of RAAC itself and they flagged no issues or alterations. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Weekly dialogue with Welsh Government and Shared Services Estates. • Links with NHS England and other Health Boards in Wales for shared learning.	**Gaps in Assurance** • Ongoing management of the issues. **Action to Address Gaps in Assurance** • Repeat surveys have been completed and additional more specific and technical surveys have been commissioned and will be undertaken as promptly as possible through the contractor to provide assurance on the work to date as well as determine further management of the risk/issues.	**Reasonable Assurance**

		• Ongoing engagement of external surveyors for regular monitoring of the situation in line with recommended timelines.		

RISK THEME	COMPLIANCE AND SAFETY				
Strategic Risk (SRR 002)	**There is a risk that there will be a significant failure of the Health Board Estates.**				
Strategic Threat	B) **Due to significant levels of backlog maintenance and structural impairment.**				**Risk Appetite Level – MINIMAL** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.
Impact	➢ Harm or injury to patients and/or staff. ➢ Adverse impacts on the delivery of care to patients across acute and non-acute settings. ➢ Non-compliance with health and safety legislation. ➢ Litigation and financial penalties.				**Risk Appetite Threshold – SCORE 8 AND BELOW** Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.
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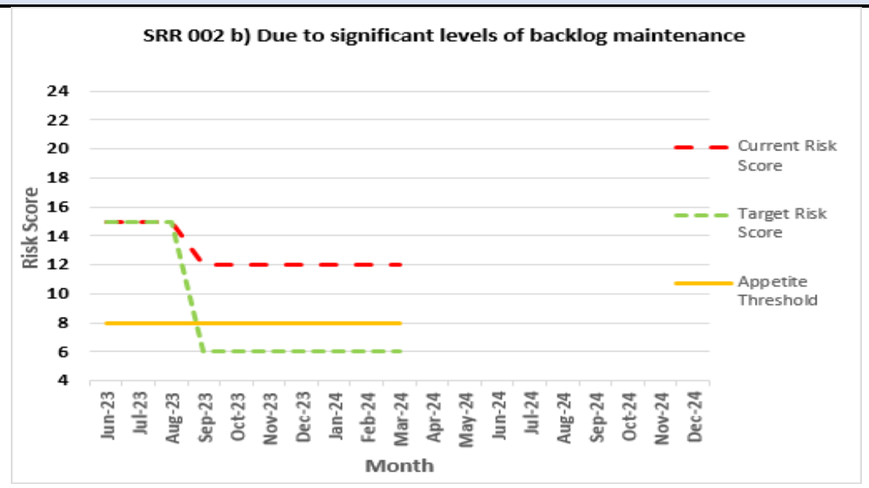
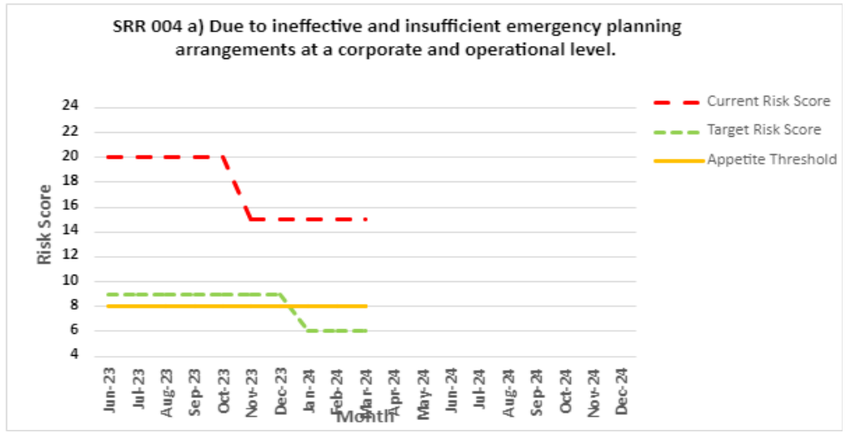
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	Partnerships, Health Protection & Planning Committee	**Likelihood**	3 *(Possible)* x	3 *(Possible)* x	
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	**2** *(Minor)*	
Last Reviewed	12 January 2024	**Risk rating**	**= 12** *(High)*	**= 6** *(Moderate)*	
Next Review Due	12 April 2024				

Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Health Board Estates Rationalisation Strategy • Health Board Estates Strategy • Health Board policies and procedures related to the maintenance of Health Board estate. • 6 Facet survey completed in 2019. • Divisional Risk Register • Multiple policies and SOPs published and communicated to staff. • A robust internal training programme in place covering all aspects of estate management including food hygiene. • Asbestos reinspection programme (over the next 3 years)	• Active estate rationalisation (including leases) is required to reduce estate demands and help prioritise capital spend to reduce backlog maintenance. • A water/ventilation engineer to enable all critical ventilation systems to undergo annual validation in accordance with HTM 04/01. • Ongoing attempts to recruit to workforce gaps and a new model of Estate Officer also being developed to assist with recruitment and retention of staff in the workforce. • Planning function leading a review of capital priorities which may help identify additional funding priority given to backlog maintenance. • Policies being reviewed and priority given to out-of-date policies, but all policies will be reviewed for effectiveness and compliance with HTM. • Drive clinical service engagement in compliance meetings where engagement is low. • Additional escalation for capital funding by the Division Estates and Facilities to support the prevention of seasonal issues and plant failure if possible.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Estates and Facilities division improved statutory compliance processes and forum led by Designated Person - DP (Divisional Director) • Divisional reporting of Statutory and Mandatory training of staff • Staff training levels are monitored and reported regularly. If areas of non-compliance are noted, targeted training can be resourced to ensure compliance. • The divisional risk register is reviewed quarterly by the Senior Management Board this is reported to the Quality & Patient Safety Operational Group. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Outcome of the Asbestos reinspection programme • Regular reporting on estate condition to the Executive Committee and Partnerships, Health Protection & Planning Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* **Internal Audit Reviews 2023- 24** 2. Estates Assurance - Estate Condition audit completed and will be with Audit Committee in February • Authorising Engineer (Shared Service Estates) reports in line with normal timelines, but active engagement with AEs through compliance processes.	**Gaps in Assurance** • AE reports have shown a deterioration in ratings last year. • Membership of HB-wide compliance groups continues to be extended providing wider HB intelligence of the issues. **Action to Address Gaps in Assurance** • The Divisional Director (and DP) has implemented a clear approach to compliance monitoring and escalation of AE reports. • HB-wide groups on compliance (such as Ventilation and water) are being widened in membership to ensure clinical services are active participants.	**Reasonable Assurance**

		• Health Board contributes to annual Estates Facilities and Performance Managements (EFPMS) at all Wales level		

RISK THEME	COMPLIANCE AND SAFETY			
Strategic risk (SRR 004)	**There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to a major incident, business continuity incident or critical incident.**			
Strategic Threat	a) Due to ineffective and insufficient emergency planning arrangements at a corporate and operational level.			**Risk Appetite Level – Minimal** Ultra-safe leading to only minimum risk exposure as far as practicably possible; a negligible/ low likelihood of occurrence of the risk after application controls**.**
Impact	➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Harm or injury to patients and/or staff ➢ Health Board breaches statutory duties under the Civil Contingencies Act 2004 ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			**Risk Appetite Threshold – Minimal Score 8 and below** Risks relating to all aspects of patient safety but also including safeguarding, staff and public security in addition risks relating to compliance and/or legal implications.
				SUMMARY The current risk level is **outside** of target level and appetite threshold. The target level to be achieved is **within** the set appetite threshold.
Impact	➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Harm or injury to patients and/or staff ➢ Health Board breaches statutory duties under the Civil Contingencies Act 2004 ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			
Lead Director	Director of Strategy, Planning and Partnerships	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	5 (*Catastrophic)*	3 *(Moderate)*
Last Reviewed	01 March 2024	**Risk rating**	**= 15** *(Extreme)*	**= 6** *(Moderate)*
Next Review Due	01 April 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
Major Incident • Health Board major incident plan in place, refreshed plan going to Board March 2024. • Local/Divisional action cards are in place. • Training undertaken service-specific relating to local response. • Regular liaison with Gwent Local Resilience Forum (Strategic and tactical) **Business Continuity (BC) /Critical Incident** • BC Policy • BC Response Guidance • BC Template • BC Exercise • BC debrief learning. • HB and LRF Plans. 3 C (Command/Control, Communication) structure in place to respond to incidents.	• Major Incident Exercise 'Euclid' planned for 20th June 2024 – Faculty in place to plan scope and detail of exercise • Testing programme of business continuity plans. • Improved Engagement with Divisions, Directorates, and service areas to embed contingency planning in the culture of the organisation, Conduct BIAs develop plans, Exercise, review, to mitigate the risks and threats to service delivery. • Repository on intranet for BC plans to be added by areas for audit, maintenance, review of interdependencies. • Joint planning with PH in response to infectious diseases and public health incidence response. • Develop further training programmes to support staff preparedness to response to an incident. • Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP). • Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Co-Ordination) structure of strategic, tactical, and Operational. • Working with ICT to scope how to maintain critical communications during loss of IT linked telephone systems or national power outages.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Departmental debrief following an incident to inform learning and enhance controls. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Debrief with key stakeholders following an incident to inform learning and enhance controls. • Report to the Executive Committee following any incident. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)*	**Gaps in Assurance** • Robustness of service business continuity plans • Further strategic and tactical training to be prepare to response to an incident. **Action to Address Gaps in Assurance** • Recommendations for strengthening resilience following testing of service business continuity plans	**Reasonable Assurance**

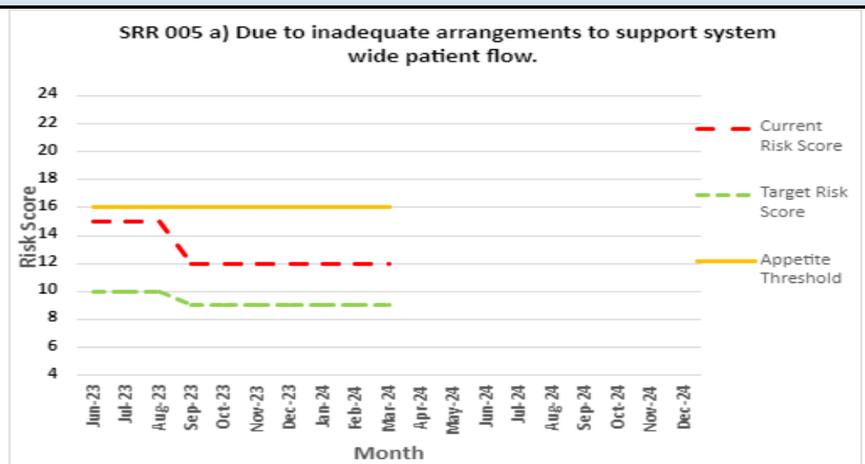
• Ongoing Participation in exercise UK, Wales, LRF and HB. • EPRR Group Established. • Repository on intranet for BC plans to be added to by areas for audit, maintenance and review of interdependencies. • Executive Team attending 2-day strategic training.	• Work with the communication team to improve incident cascade during an event to ensure Health Board wide awareness in a timely manner. • Continue to promote awareness in a timely manner. • Continue to promote awareness of the requirement for BC across the Health Board. • Continuing participation in multi-agency exercises. • Internal strategic on call training	**Internal Audit Review(s)** 1. Business Continuity Planning 2023-24 (Q2) outcome report published – Reasonable Assurance • Outcome and feedback from national exercises		

RISK THEME	SERVICE DELIVERY			
Strategic Risk (SRR 005)	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.**			
Strategic Threat	**a) Due to inadequate arrangements to support system-wide patient flow**			
Impact	➢ Avoidable deaths or significant harm ➢ Delays in releasing ambulances from hospital sites back into the community ➢ Delayed discharges from acute and non-acute settings resulting in deteriorating patients; ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	**Likelihood**	3 *(Possible)* x	3 *(Possible)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Catastrophic)*	3 *(Minor)*
Last Reviewed	12 January 2024	**Risk rating**	**= 12** *(High)*	**= 9** *(High)*
Next Review Due	12 April 2024			

Risk Appetite Level - Open
Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.

Risk Appetite Threshold – Open SCORE 16 AND BELOW
Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.

SUMMARY
The current risk level is **outside** of target level but **within** appetite threshold.



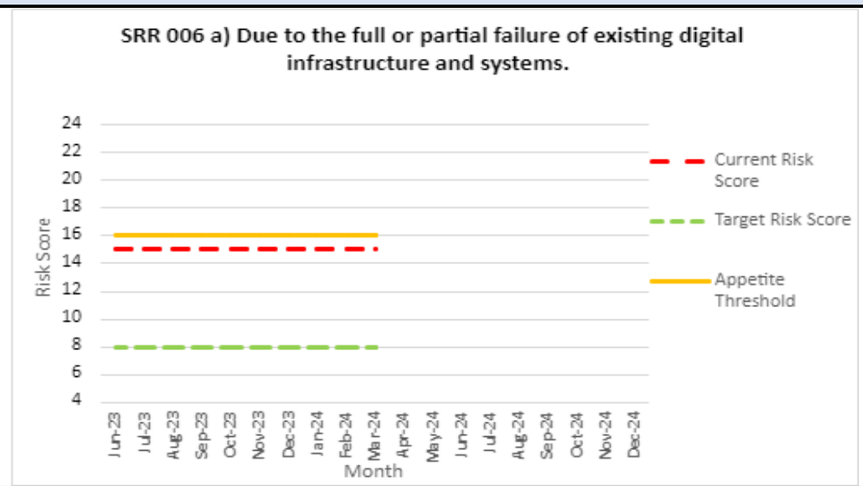
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Escalation Policy. • Performance and Accountability Framework • Major incident Procedures • Daily X-site flow meetings - Twice daily flow calls to receive updates from all acute sites as well as community services. Allowing opportunity for escalation of risks. • Escalation communications – ambulance focussed email escalation when congestion begins to build up on the GUH forecourt. Aim to escalate to senior management to aid in quick risk-based decision making. Includes members of the Executive team. • Weekly safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Action focussed and task driven. • Range of performance measures/metrics in place • Repatriation mechanism with neighbouring Health boards – Daily repatriation calls between head of operations and counterparts in south Wales to ensure regular dialogue to repeat patients between hospitals and health boards. • Maximum Capacity Plan – Executive team agreed maximum capacity plan to ensure there is clear description ad guide for where extra capacity can be accessed to ensure patient flow is maintained. • Planned care recovery meetings with the NHS execs. • Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls. • WG – IQPD meetings to review areas of focus.	• Escalation framework – evidence suggesting inconsistent escalation of ambulance position / long waits and rationale. • Winter planning – Ahead of winter 23/24 there are a series of meetings which will ensure that tangible / practical plans are put in place to ensure: • Focus • Processing power • Capacity • Mental health-focussed flow meeting – implement a MH-focussed daily forum to ensure the flow requirements and risk profile is understood across all MH sites. • Build in more impromptu, OoH and site visits to check on processes i.e., patient safety, risk, and performance across the Divisions. • Improve regional acceptance of flow processes with neighbouring Health Boards. • Industrial Action – command and control structures across gold, silver and bronze to ensure service continuity and patient safety throughout any medical strikes.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • The Escalation Framework has been enacted and is effective in mitigating threats and impact to services. • Performance report against measures/metrics **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Divisional Assurance reviews. • Performance against measures/metrics reported to the Executive Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • **Internal Audit Reviews** 1. Intra-site Patient Transfers (Q1) - Not Yet Reported (expected to be received at Audit, Risk & Assurance Committee in February 2024. • External inspections/visits.	**Gaps in Assurance** • Evidence that the Escalation Framework is delivering improvements across all areas of patient flow e.g., ambulance handovers. • The impact of the Performance and Accountability framework in improving patient flow **Action to Address Gaps in Assurance** • Close monitoring and reporting of the frameworks in practice to support learning and improvements.	**Reasonable Assurance**

RISK THEME	SERVICE DELIVERY			
Strategic Risk (SRR 006)	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**			
Strategic Threat	a) Due to the full or partial failure of existing digital infrastructure and systems.			
Impact	➢ Harm or injury to patients and/or staff ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Data breaches ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			
Lead Director	Director of Digital	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Finance & Performance Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	5 *(Catastrophic)*	4 *(Major)*
Last Reviewed	01 March 2024	**Risk rating**	**= 15** *(Extreme)*	**= 8** *(Moderate)*
Next Review Due	01 April 2024			

Risk Appetite Level - OPEN
Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold - Score 17 and below
Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.

SUMMARY
The current risk level is outside of target level but within appetite threshold. The target level to be achieved is within the set appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall)*
• Cyber has developed a Remedial Action Plan to address issues identified within the NIS CAF assessment 2021. This Action Plan has also supported ABUHB risk remediation responses to ABUHB's NIS CAF Risk Register which by CRU to address risks identified during the NIS CAF assessment. The remedial actions proposed have been accepted by CRU and progress will be reviewed annually. • Director of Digital (SIRO) and Chief Information Officer (Deputy SIRO) SIRO trained. • New Information Governance and Cyber Security governance and assurance processes reviewed and implemented. • Governance group terms of reference agreed. Meetings started in November 2023. • Cyber is fully engaged with IG colleagues to implement the recommendations of the Templar report. Cyber now supports all the Governance and Assurance Groups intending to increase cyber security awareness and build cyberculture amongst non-ICT staff • Cyber now undertakes scheduled monthly vulnerability scans of all ABUHB-managed servers to include third-party servers. The results of these scans will now be reported in the Monthly Cyber Report. • Cyber has also worked with Business Systems and Desktop Teams to ensure that patching compliance for internally managed systems and third-party systems is monitored and reported monthly. Monthly review meetings are held between Cyber and the Teams to review compliance levels against policy. Results are captured within the monthly Cyber Report. • Cyber has worked with ICT Support Teams and the Log4j version 2 vulnerability has been resolved within the Health Board. The less service impacting Version 1 is being managed through ICT Departmental risk management process. • Cyber has maintained the use of Trust ware for all emails Trustwave provides inspection and protection from malicious links embedded within emails. • Cyber has begun the roll out simulated phishing campaigns. The initial phish has been tested on ICT Department and reported within the Cyber Report. Cyber will continue campaigns during 2023 to increase email security awareness among staff.	Implement the recommendations from Templar report: • Outline a step by step process of how the proposed risk treatments need to be implemented. This should include the activities to be performed, who is responsible and deadlines for completion. • Complete any outstanding policy and process development, ensuring there is engagement with non ICT teams including the SIRO and board • Ensure ICT disaster recovery policies are complete and refer to any system specific recovery processes. • Ensure non ICT teams are aware of disaster recovery policies and processes and engaged in developing system breach/failure response definition. • Complete a policy and process review after each incident to	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Internal directorate meetings setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular reporting on progress to the Finance & Performance Committee on our cyber security action plan. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* Internal audit • Cyber security in April 2023 provided Digital with a substantial audit for its cyber security	**Gaps in Assurance** • Oversight from NHS Wales Cyber Resilience Unit. **Action to Address Gaps in Assurance**	**Reasonable assurance**

• Cyber has also introduced scenario-based incident response exercising using National Cyber Security Centre developed 'Exercise in a box' the aim is to assess our current skills in responding to real-life cyber security incident scenarios and to identify improvements. Cyber plans to run several more exercises during 2023	identify if anything could be improved in detection, resolution or prevention of a cyber security incident. Also, ensure the same is done whenever there are significant system changes. • Develop the policy and processes for identity and access management to ensure that privileged and critical system accounts are reviewed periodically e.g. 6 to 12 months, with other accounts reviewed through joiners/starters, movers and leavers processes. • Investigate circumstances where dedicated devices can be used for critical system access • Consider plans for certification of users and devices and how those certifications can be used. • Consider how to monitor privileged accounts e.g. with additional logs managing not just by exception but random and planned audits • Assess whether MFA can be implemented for privileged user accounts • Review any critical system logs that are created • Update systems or request updates to create additional logs where possible and include creation of logs on user devices in any investigation • Investigate a means of alerting for specific log conditions • Consider collective identification of appropriate tools and working with other OES within NHS Wales to identify appropriate tools.	improvement plan, reporting and backup systems.		

RISK THEME	SERVICE DELIVERY			
Strategic Risk (SRR 006)	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**			
Strategic Threat	b) Due to an adverse impact on service delivery in the implementation of the new digital systems.			
Impact	➢ Harm or injury to patients and/or staff ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Data breaches ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			
Lead Director	Director of Digital	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Finance & Performance Committee	**Likelihood**	3 *(Possible)* *x*	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	4 *(Major)*
Last Reviewed	01 February 2024	**Risk rating**	**= 12** *(High)*	**= 8** *(Moderate)*
Next Review Due	01 April 2024			

Risk Appetite Level - OPEN
Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold - Score 17 and below Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.

SUMMARY
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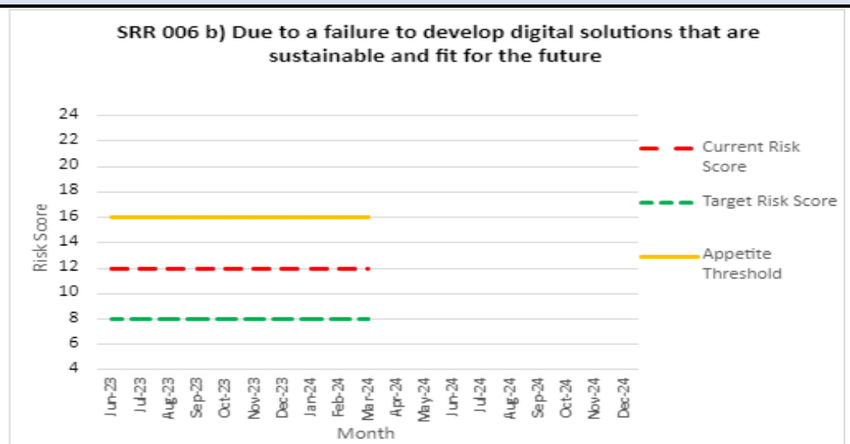

Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Adoption of formal project management methodologies PRINCE 2 to ensure project plans are developed in conjunction with services • Formal governance arrangements in place through project boards and programme boards where risks and issues are managed and mitigated • Each project has a senior responsible officer from the service who can provide challenge and assurance over the delivery of the project work packages • Each clinical project has a clinical lead who would advise and support potential impacts on service delivery caused by the implementation of new digital services • Business change team in place to support services in improvement of clinical and administrative processes • Benefits team in place who identify, track and ensure any benefits are realised which will ultimately improve service delivery • Projects support backfilling of clinical time where required	• Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee • Assurance activities included in project framework including clinical safety, information governance, health records and cyber security • An overarching Digital Portfolio Progress Group is in place to receive programme updates, manage risk and issue escalations and provide multi-disciplinary assurance over digital projects • Business change work includes a service readiness impact assessment to enable the project team to develop a realistic plan that incorporates service change requirements • Aggregated view of risks and issues available to pick up common themes and impact for early intervention or escalation • Aggregated view of digital Lessons Learned available and lessons are reviewed during project initiation for best chance of success	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Internal directorate meetings setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans • Project Boards meet monthly and report into the quarterly Digital Portfolio Progress Group • Digital Directorate meetings being held monthly to monitor risks to regularly update and to provide assurance over outstanding action plans • Risk management approach and escalation processes in place in line with the Health Board's Risk Framework **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular Reporting to the Finance & Performance Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)*	**Gaps in Assurance** • Governance and assurance groups • Oversight from NHS Wales Cyber Resilience Unit **Action to Address Gaps in Assurance** Information Governance Sub Committee Terms of Reference have been drafted and are under review. Cyber Security Subgroup ToR also drafted, and membership agreed.	**Reasonable assurance**

		• Cyber security in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. Internal Audit • Benefits Management review – Outcome Substantial Assurance • Stakeholder Engagement on IT Projects 2023/24 Q3 – Outcome Substantial Assurance		

RISK THEME	SERVICE DELIVERY			
Strategic Risk (SRR 006)	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**			
Strategic Threat	c) Due to failure to develop digital solutions that are sustainable and fit for the future.			
Impact	➢ Harm or injury to patients and/or staff ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Data breaches ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			
Lead Director	Director of Digital	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Finance & Performance Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	4 *(Major)*
Last Reviewed	07 February 2024	**Risk rating**	**= 12** (High)	**= 8** *(Moderate)*
Next Review Due	01 April 2024			

Risk Appetite Level – OPEN
Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold - Score 17 and below
Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.

SUMMARY
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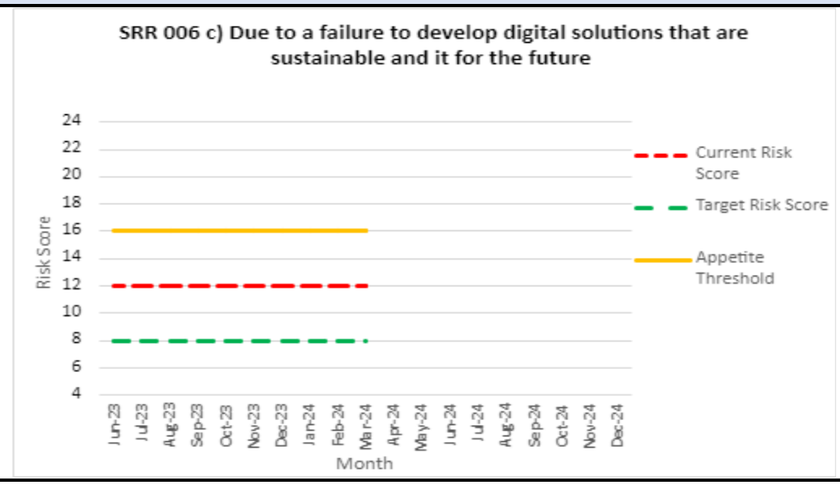


Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• New Digital Service Request process in place which provides governance in several key areas: 1. Information Governance – ensuring new services have appropriate controls to keep patient information safe. 2. Cyber Security – ensuring new services adopted or developed meet the requirements of the cyber assessment framework. 3. Patient Safety – ensuring services do not introduce any patient safety risks. 4. Records – ensuring new systems comply with the requirements of records management. • Strong business analysis function in operation which ensures the "as-is" and "to-be" process mapping is undertaken which provides assurance that new services implemented are fit for purpose and delivery what stakeholders require.	• New governance structures to be put in place by the end of 2023. • Monthly/quarterly Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities • Annual planning processes to include formal DDAT Annual Operational Plan aligned with service priorities identified in IMTP process • New Digital Request processes refresh with senior leadership scrutiny of requests, implementation of new prioritisation process and quarterly reporting to DDAT sub-committee • Automation of request process via 'Seren' the ICT Portal • Portfolio optimisation to ensure the resources of the service are aligned to key priorities	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Live Microsoft Team Planning Board (Kanban) to manage new digital service requests • Fortnightly internal New Digital Service Requests meetings • Internal directorate meetings setup monthly to monitor risks and to regularly update and to provide assurance over outstanding action plans. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular Reporting to the Finance & Performance Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)*	**Gaps in Assurance** To be determined once the new governance changes have been implemented. **Action to Address Gaps in Assurance**	**Reasonable assurance**

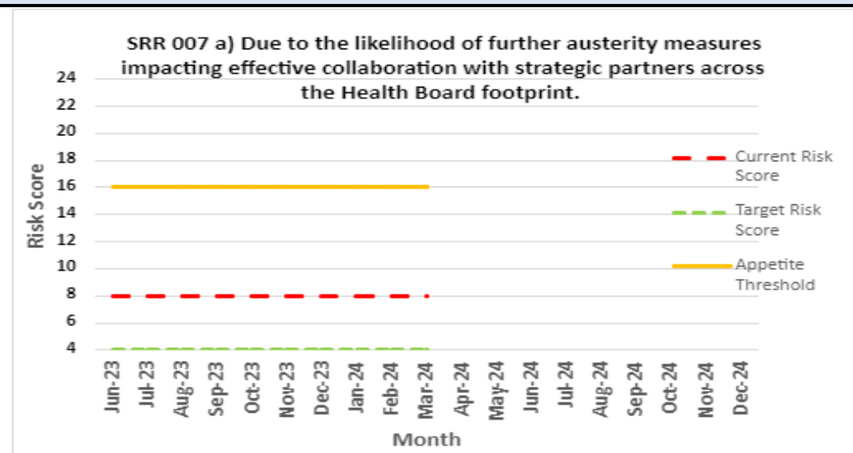
• Business change function which ensures implemented systems are effective and deliver the benefits required. • Formal framework in place for the adoption of new digital services and best practice guidance followed. • Operational delivery aligned to ITIL standards		• Cyber security in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. Internal Audit • LINC Programme 23/24 – Not yet undertaken. • Network Infrastructure (VPN) 23/24 Q3 - Outcome reasonable assurance		

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING			
Strategic Risk (SRR 007)	**There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population.**			
Strategic Threat	a) **Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.**			
Impact	➢ Unmet patient need resulting in harm ➢ Ineffective use of combined resources ➢ Delayed decision making ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Failure to deliver health board priorities, required improvements and achieve longer-term sustainability ➢ Reputational damage and loss of public confidence			
Lead Director	Director of Strategy, Planning, and Partnerships.	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	2 *(Unlikely)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	2 *(Minor)*
Last Reviewed	10 January 2024	**Risk rating**	**= 8** *(Moderate)*	**= 4** *(Moderate)*
Next Review Due	10 April 2024			

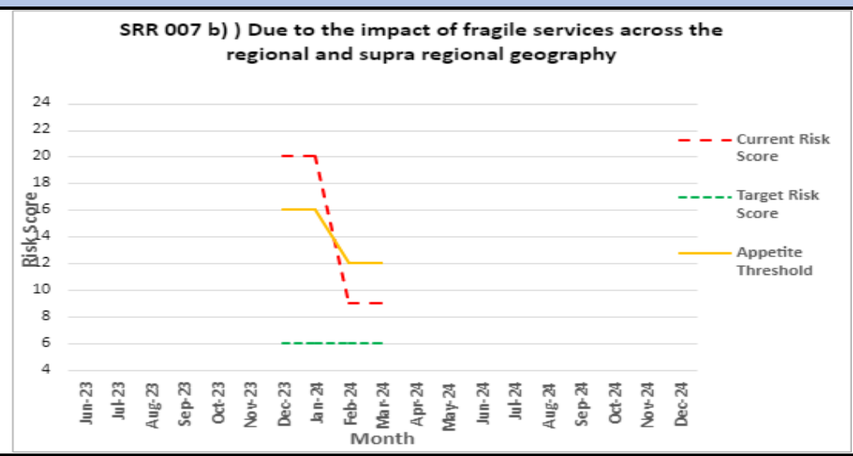
Risk Appetite Level - OPEN
Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.

Risk Appetite Threshold - **SCORE 16 AND BELOW**
All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.

SUMMARY
The current risk level is **outside** of target level but **within** appetite threshold. The target level to be achieved is **within** the set appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
The Health Board plays an active role in a range of formal partnership arrangements to enable integrated working for the population including: 1. **The Gwent Public Services Board (Gwent PSB)** brings public bodies together to work to improve the economic, social, environmental, and cultural well-being in Gwent. They are responsible, under the Wellbeing of Future Generations (Wales) Act, for overseeing the development of the new Local Wellbeing Plan which is a long-term vision for the area. 2. **The Gwent Regional Partnership Board** As set out in the Partnership Arrangements (Wales) Regulations 2015, local authorities and local health boards (RPB) manage and develop services to secure strategic planning and partnership working. RPBs also need to ensure effective services and care and support is in place to best meet the needs of their respective population. Through these statutory forums formal partnership arrangements take place. In addition to these statutory forums the Health Board has a range of interfaces with key stakeholder bodies, including regular liaison with local authorities, neighbouring Health Boards, housing associations, and third-sector partners. Joint working between operational teams including integrated operational arrangements and combined multidisciplinary teams, for example, Community Resource Teams	• Governance review of Regional Partnership Board undertaken in August 2023. • Renewed Strategy for strategic partnership Capital in place and revised governance processes. • New Long-Term Strategy for Health Board to focus on Partnership approach.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • PMO reporting to the Director of Strategy, Planning and Partnerships. • Regional Leadership Group Reporting **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Assurance reporting to the Population Health, Partnerships, and Planning Committee. • Assurance reporting to the Board. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Internal Audit Governance Review 2023/24 (Q2) – Underway – due to be reported to the Audit, Risk & Assurance Committee in February 2024.	**Gaps in Assurance** • Systematic reporting of outcomes • Systematic evaluation of schemes • Governance of financial control arrangements **Action to Address Gaps in Assurance** • Implementation plan to be developed following RPB governance review. • Health Board strategy development approach to focus on partnership approach.	**Reasonable Assurance**

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING				
Strategic Risk No: SRR 007B	**There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population**				
Strategic Threat	b) Due to the impact of fragile services across the regional and supra regional geography				**Risk Appetite Level - OPEN** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.
Impact	➢ Unmet patient need resulting in harm ➢ Ineffective use of combined resources ➢ Delayed decision making ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Failure to deliver health board priorities, required improvements and achieve longer-term sustainability ➢ Reputational damage and loss of public confidence				**Risk Appetite Threshold - SCORE 12 AND BELOW** All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change. **SUMMARY** The current risk level is **outside** of target level but **within** appetite threshold. The target level to be achieved is **within** the set appetite threshold.
Lead Director	Director of Strategy Planning and Partnerships	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x	
Initial Date of Assessment	04 January 2024	**Impact**	*3 (Moderate)*	2 *(Minor)*	
Last Reviewed	16 January 2024	**Risk rating**	***= 9*** *(High)*	**= 4** *(Moderate)*	
Next Review Due	16 April 2024				

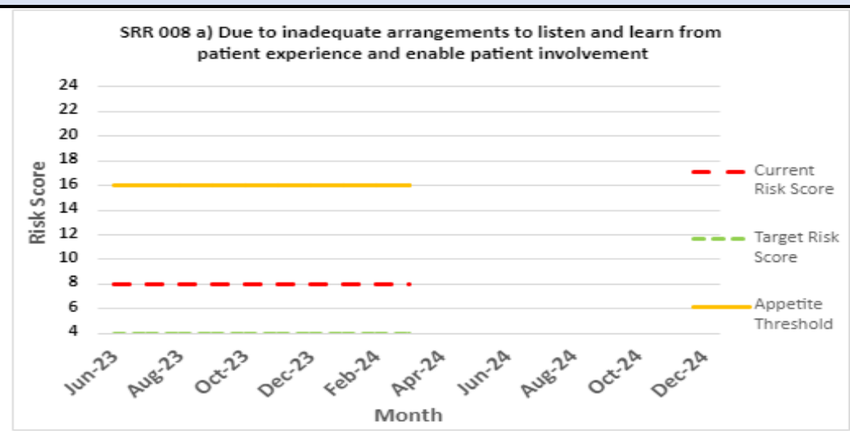
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
A robust Southeast Wales Regional planning infrastructure has been established with clear governance mechanisms in place with attendance from CEO, DoP and COO. The Regional Portfolio Delivery Board brings the participating health boards together to review all regional service projects, to assess progress against agreed timelines and to agree additional measures / escalations in the event of identified issues and risks. This Board then reports to an Oversight Board with Chief Executive membership. 4 workstreams are established (Orthopaedics, Ophthalmology, Diagnostics and Cancer) and the UHB is well represented and engaged on all. Where appropriate workstreams are underpinned by a Memorandum of Understanding between the participating health board, setting out their respective commitment to collaborative regional planning where this can enhance service sustainability, quality, and efficiency. When service issues span regions, arrangements are set up on a bespoke basis, for example the Vascular Project Board and the Interventional Radiology (IR) project. In addition to these formal arrangements, the Health Board has a range of informal planning networks and communication channels, with an ongoing commitment to communication, sharing best practice and advising of anticipated service issues and risks.	The southeast Wales health boards have agreed revised joint priorities and working arrangements for regional planning in 2024, following a recent review workshop attended by Chief Executives. The revised priorities / forward work plan includes the following: - • An absolute commitment to delivering on the existing regional programmes of work but with recognition that these need to be 're-baselined' for 2024/25 to ensure there is a continued regional consensus on objectives, outcomes, and planning assumptions. • The need to review the current regional working governance arrangements, to ensure these remain fit for purpose. • The need to further review the indicative list of fragile services for the Southeast region and begin considering the regions response to these. • The need to develop a regional clinical service plan that can articulate what a long-term sustainable secondary care system looks like for Southeast Wales that can then inform local decisions. Discussion to be had at all Wales NHS CEOs and NHE Executive on governance and infrastructure to take forward cross regional planning to be reviewed considering IR and Neonatal work	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Service Divisions reporting to the Chief Operational Officer **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Assurance reporting to the Population Health, Partnerships, and Planning Committee. • Assurance reporting to the Board. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)*	**Gaps in Assurance** • Under review **Action to Address Gaps in Assurance**	**Reasonable Assurance**

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING			
Strategic Risk (SRR 008)	**There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.**			
Strategic Threat	**a) Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.**			
Impact	➢ Adverse impact on patient experience ➢ Failure to deliver health board priorities, required improvements and achieve longer-term sustainability ➢ Reputational damage and loss of public confidence ➢ Failure to deliver Duty of Quality			
Lead Director	Director of Nursing	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	**Likelihood**	2 (Unlikely) x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	2 *(Minor)*
Last Reviewed	11 January 2024	**Risk rating**	**= 8** *(High)*	**= 4** *(Moderate)*
Next Review Due	11 April 2024			

Risk Appetite Level – Open
Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure

Risk Appetite Threshold – Open SCORE 17 AND BELOW
All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.

SUMMARY
The current risk level is **outside** of target but within the appetite threshold. Target level is **within** the set appetite threshold.



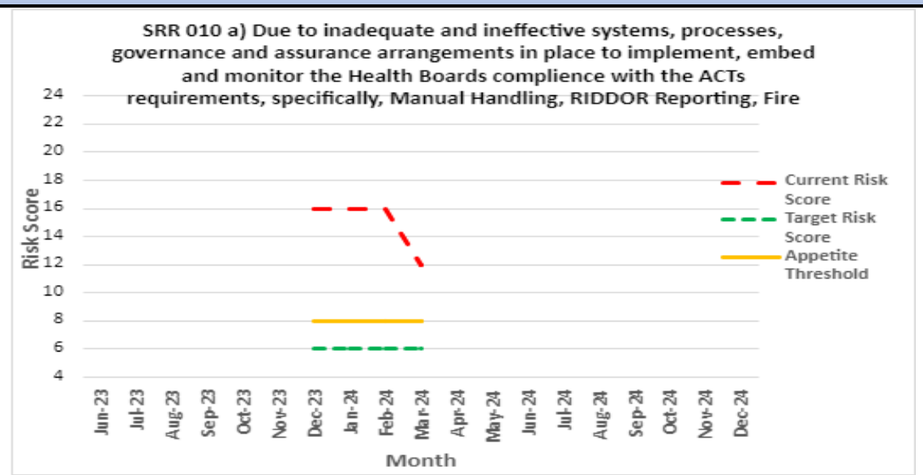
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Corporate Engagement Team • Patient Experience and Involvement Strategy- organisational ownership • Person Centred Care (PCC) Surveys via CIVICA • PCC KPI's (support PCC Quality pillar) • 'You said…… we did' public facing information for service areas. • PLO service at GUH • Introduction of PALS Service (Oct 23) • Volunteer Patient Experience Feedback • Collaboration to recruit community listeners to support Dementia Awareness • Digital patient stories to support listening and learning. • Patient Experience and Involvement Strategy • DATIX	• Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress. • PCCT staff training to support Civica data entry and retrieval. • Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners. • Employment of dedicated PALS team in progress who will have a key role in gaining feedback from patients, staff, and relatives. • Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data. No SMS provision. • National directives around new national surveys that need to be managed additional to internal roll out programme. • Volunteer feedback to be reviewed to identify themes.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Person Centred Care Team oversee patient experience through dedicated work programme and link in with divisional teams. • Concerns are fed back to divisional teams when identified. • Outcome of the volunteer feedback to drive improvements. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO) • Listening and Learning reported through QPSOG/ Outcomes Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • LLais Reports • HIW inspections	**Gaps in Assurance** • No SMS provision to increase the number of PCC surveys. • No single point of contact or 'drop in' provision for patients/families/staff to raise initial patient experience concerns. **Action to Address Gaps in Assurance** • Discussions with VBHC team to consider SMS through DrDoctor • PALS Single point of contact is being established. PALS officers will have key role in patient experience and involvement- including establishing 'drop in' clinics on hospital sites should patients/staff/relatives wish to discuss concerns. • PCC KPI's and common themes need to be identified and reported through the PCC Survey. These will be added to a template patient experience report and CIVICA surveys will be built into ward accreditation. • Implement PALS DATIX Module	**Reasonable Assurance**

RISK THEME	COMPLIANCE & SAFETY			
Risk No: SRR 010	**There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974**			
Strategic Threat	• Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.			
Impact	➢ Unintended physical harm; ➢ Punitive actions from the Health and Safety Executive (HSE); ➢ Increased levels of staff sickness; ➢ Loss of estate due to unsafe environments; ➢ Financial implications; ➢ Adverse publicity; and, ➢ Reputational damage			
Lead Director	Director of Therapies & Health Science	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	**Likelihood**	3 (*possible*) **x**	**2** (*Unlikely*) **x**
Initial Date of Assessment	01 December 2023	**Impact**	***4*** *(Major)*	**3** *(Moderate)*
Date Reviewed	01 March 2024	**Overall Risk Rating**	**= 12** *(High)*	**= 6** *(Moderate)*
Date of Next Review	01 April 2024			

Risk Appetite Level - MINIMAL.
Any risk that has a MINIMAL risk appetite level should be managed to a **Score of 8 or below**.

Risk Appetite Threshold - Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible / low likelihood of occurrence of the risk after application of controls**.**

SUMMARY
The current risk level is **outside** of target level and **outside** appetite threshold. The target level to be achieved is **within** the set appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices. • Health and Safety Policies and Procedures • Dedicated Health and Safety site on ABPULSE • Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'. • Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) • Partial Programme of Health and Safety Monitoring (Active & Reactive) • Corporate and Directorate Health and Safety Risk Register established.	• Implementation of Health, Safety, and Fire Improvement Plan for 2023/24 to address 7 risk areas of concern. • Health and Safety Governance and reporting arrangements (Health and Safety Committee) • Develop and Implement a 3-year health and safety culture plan, including the implementation of a new Health and Safety Management System • Suitable and Sufficient Risk assessments (including local risk assessments, specific fire risk assessments, and fire risk assessments) • Consultation and communication with the workforce regarding compliance with the Act • New ways of working with Divisions to ensure accountability for health and safety is recognised. • Implement key performance indicators to monitor health and safety compliance. • Review the governance arrangements for the Health & Safety Committee • Health and Safety Policies and Procedures to be reviewed. • Board Training /development • Onboard further Manual Handling trainers across the organisation to improve compliance. • Scope for training non-Health Board staff • Learning from events to be documented and communicated to the organisation.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Health and Safety compliance data extracted from ESR and Datix and reported **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Established monitoring of H&S at the Executive Committee • Corporate H&S report risk and assurance to the Health and Safety Committee • Established monitoring of H&S at the PQSO Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Performance reviews at All Wales Health and Safety Management Steering Group • Internal Audit – H&S processes Review to be included in 2024/25 Plan. • South Wales Fire & Rescue Service fire safety audit programme. • Health and Safety Executive reviews/inspections.	**Gaps in Assurance** • Implementation of a health and safety performance report • Health and Safety Committee Membership and governance to be reviewed to ensure there is robust scrutiny and challenge on compliance with the Act. • Compliance on completion of risk assessments and mitigating actions **Action to Address Gaps in Assurance** • Revise accountability arrangements for Health and Safety being progressed as part of the organisational Health & Safety Governance Framework. • Review the membership and ToRs of the Health and Safety Committee • Risk assessments and mitigating actions to be documented and reported regularly to demonstrate progress against the Improvement Plan	**Negative Assurance**

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	16 April 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Audit Risk and Assurance Committee Work Plan 2024/25
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Audit Risk and Assurance Committee is asked to consider the draft Committee work plan appended to this report for approval. The work plan has been developed with due regard to recommendations from the Committee Mid-Year Self-Assessment and the 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 (to be agreed by the Board May 2024);
- 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.

Cefndir / Background

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.

In line with good governance practice, a committee work plan has been developed to ensure statutory requirements for items of Committee business are scheduled in across the year. The work plan can therefore be utilised as a tool for informing and pre-empting committee business and support the agenda setting function.

Asesiad / Assessment

The Committee is requested to approve the Committee work plan as outlined in **Appendix 1** noting that the work plan will be presented at each Committee meeting for oversight and noting.

The work plan will be used to inform Committee business alongside the Board Assurance Framework which will seek to highlight areas of limited or reduced gaps in assurance.

Throughout 2023-24, the Committee requested an increased level of assurance in relation to Clinical Audit, citing the 2022-2023 Limited Assurance Internal Audit and the Committee's concerns about the absence of a clinical audit plan for 2023-2024. However, over the course of the year, improvements were made in this area, including the appointment of an Assistant Director for Patient Quality and Safety and the implementation of AMaT for recording and learning from completed audits.

At its November meeting, the Committee agreed that the Patient Quality, Safety, and Outcomes Committee (PQSOC) as per its Terms of Reference would be the forum that would seek assurance on the clinical outcomes and improvements made as a result of clinical audit, systems, practices, and results against agreed standards and the Audit, Risk and Assurance Committee, as per the NHS Wales Audit Committee Handbook and its Terms of Reference would seek assurance on the overall plan, it's fitness for purpose and it's delivery, which will include the following areas:-

- Does the organisation have a plan - and is it fit for purpose?
- Is it completed on time?
- Does it cover all relevant issues?
- Is it making a difference and leading to demonstrable change?
- Is change supported by recognised improvement methodologies?
- Does the organisation support clinical audit effectively?

Assurance will be provided through the following mechanisms: -

- Clinical Audit Plan;
- Annual Report on Clinical Audit Activity;
- Mid-Year Update on delivery of the Clinical Audit Plan;
- Internal and External Audit Reviews; and,

- The Internal and External Recommendations Tracker.

If the Committee is unable to obtain reasonable assurance regarding the progress of implementing clinical audit recommendations, it may request that the Executive Lead for the audited area attend the Committee to provide the necessary assurance.

Argymhelliad / Recommendation

The Committee is requested to:

- **RECIEVE** and **APPROVE** the proposed Committee work plan and **NOTE** that it will be brought forward to each future Committee meeting for oversight;
- **AGREE** to reference and utilise the Committee work plan to inform committee meeting agendas and items for discussion in conjunction with the Risk Management Framework.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The monitoring and reporting of committee business is a key element of the Health Boards assurance framework
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Committee Forward Programme monitors delivery of objectives.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

ANNUAL PROGRAMME OF BUSINESS 2024/25

AUDIT, RISK & ASSURANCE COMMITTEE

This Annual Programme of Business has been developed with reference to:

- Aneurin Bevan University Health Board's Standing Orders;
- The discharge of the business needs of the individual Directorates
- The Health Board's Integrated Medium-Term Plan and related Annual Delivery Plan;
- The outcomes of the Committee self-assessment for 2023 and the Structured Assessment 2023 recommendations
- The Board's Assurance Framework and Corporate Risk Register; and
- Key statutory, national, and best practice requirements and reporting arrangements.

Area of Focus as per Standing Orders:
The Audit, Risk and Assurance Committee will provide assurance to the Board of the effectiveness of its arrangements for handling reservations and delegations.

The Committee has been established to enable the scrutiny and review of matters related to audit, financial accounting, assurance, and risk management, to a level of depth and detail not possible in Board meetings.

The purpose of the Committee is to support the Board and Accounting 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 by:

- independently monitoring, reviewing, and reporting to the Board on the processes of governance, risk management and internal control in accordance with the standards of good governance determined for the NHS in Wales;
- advising the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further;
- Maintaining an appropriate financial focus demonstrated through robust financial reporting and maintenance of sound systems of internal control; and
- Working with the other committees of the Board to provide assurance that governance and risk management arrangements are adequate and part of an embedded Board Assurance Framework that is ‘fit for purpose’.

DRAFT

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2024/25					
			Quarter 1		Quarter 2		Quarter 3	Quarter 4
			16th April 2024	May 21st *Draft Accounts*	July 9th *Final Accounts*	10th Sept 2024	12th Nov 2024	18th Feb 2025
Preliminary Matters								
Attendance and Apologies	**SI**	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 2024/25	**An**	Chair & DofCG	√					
Review of Committee Programme of Business	**SI**	Chair	√	√	√	√	√	√
Annual Review of Committee Effectiveness 2023/24 to include a review of the Terms of Reference	**An**	Chair & DofCG				√		
Committee Annual Report 2023/24	**An**	Chair & DofCG		√				
Corporate Governance, Risk & Assurance								
Receive assurance on implementation of the Governance Priorities set out within the IMTP 2022-25	**BI**	DofCG				√		√
Review and report upon the adequacy of arrangements for declaring, registering, and handling interests	**An**	DofCG					√	
Receive full report of all offers of gifts and hospitality as declared	**An**	DofCG					√	
Compliance with Ministerial Directions	**BI**	DofCG				√		√
Compliance with Welsh Health Circulars (WHCs)	**BI**	DofCG				√		√
Review of Standing Orders, Standing Financial Instructions, and Scheme of Delegation	**An**	DofCG						√
Compliance with regulatory requirements	**An**	DofCG						√
Audit Recommendations Tracking Report	**SI**	DofCG	√	√	√	√	√	√
Annual Review of Risk Management Framework	**An**	DofCG						√
Report on the Implementation of the Risk Management Framework	**BI**	DofCG				√		
Committee Risk & Assurance Report	**SI**	DofCG	√	√	√	√	√	√

DRAFT

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2024/25					
			Quarter 1		Quarter 2		Quarter 3	Quarter 4
			16th April 2024	May 21st *Draft Accounts*	July 9th *Final Accounts*	10th Sept 2024	12th Nov 2024	18th Feb 2025
Financial Governance and Control								
Report of the use of Single Tender Action	**SI**	DofF&P	√			√	√	√
Report of Losses and Special Payments *(May report will be included in the Accounts)*	**BI**	DofF&P		√			√	
To Approve Reviewed and Updated Financial Control Procedures	**Ad hoc**	DofF&P						
Annual Report and Accounts								
To consider the approach and timelines for the Annual Report and Accounts	**An**	DofF&P & DofCG						√
Review the Health Board's Annual Report (Overview & Performance Section) **(Part 1)**	**An**	DofCG		√	√			
Review Draft/Final Accountability Report, including Annual Governance Statement **(Part 2)**	**An**	DofCG		√	√			
Review Draft/Final Annual Accounts and Financial Statements **(Part 3)**	**An**	DofF&P		√	√			
Audit Enquiries to those charged with Governance and Management	**An**	DofF&P		√				
Audit Wales, Audit of Accounts (ISA 260) including Letter of Representation	**An**	AW			√			
Final Annual Accounts Memorandum	**An**	AW					√	
Receive the Annual Head of Internal Audit Opinion (including Specialised)	**An**	HofIA			√			
Agree a recommendation to the Board in respect of the audited annual report and accounts	**An**	Chair			√			
Counter-Fraud								
Review of the Counter Fraud, Bribery and Corruption Policy *(Feb 2026)*	**3-Yearly**	DofF&P	-	-	-	-	-	-
Receive the Counter Fraud Annual Report	**An**	HofCF			√			√
Agree the Counter Fraud Annual Workplan	**An**	HofCF	D	√D				
Receive a Quarterly Report on Counter Fraud Activity	**Quarterly**	HofCF		√		√		√
Agree the Counter Fraud Functional Standard Return Declaration	**An**	HofCF			√			

DRAFT

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2024/25					
			Quarter 1		Quarter 2		Quarter 3	Quarter 4
			16th April 2024	May 21st *Draft Accounts*	July 9th *Final Accounts*	10th Sept 2024	12th Nov 2024	18th Feb 2025
Receive the Post Payment Verification Annual Report, including, the Annual Workplan for 2024-25	**An**	PPV Manager			√			
Receive a Mid-Year update in respect of Post-Payment Verification Activity	**An**	PPV Manager					√	
Clinical Audit								
Receive the Clinical Audit Activity Annual Report 2023 - 2024	**An**	Medical Director		√				
Agree the Clinical Audit Plan 2024 - 2025	**An**	Medical Director		√				
Mid-year Report on the delivery of the Clinical Audit Plan	**An**	Medical Director				√		
Internal Audit (Including Specialised Audit) – NWSSP Audit & Assurance Services								
Agree the Internal Audit Annual Workplan	**An**	HofIA	√					
Receive Internal Audit Progress Reports	**SI**	HofIA	√	√	√	√	√	√
Receive Internal Audit Review Reports, reviewing the adequacy of executive & management responses to any issues identified, ensuring that they are acted upon	**SI**	HofIA	√	√	√	√	√	√
Review and approve Internal Audit terms of reference (charter) and the effectiveness of internal audit	**An**	HofIA with Chair		√				
External Audit – Audit Wales								
Receive the External Audit Annual Audit Report	**An**	AW		√				
Agree the External Audit Annual Plan	**An**	AW	D√	√				
Receive the draft external auditor's opinion on the quality account	**An**	AW						
Receive the 2024 Structured Assessment	**An**	AW					√	
Receive External Audit Progress Report 2024-25	**SI**	AW	√	√	√	√	√	√
Review of External Audit Reports including results & the adequacy of executive & management responses to any issues identified, ensuring that they are acted upon	**Ad hoc**	AW						
Consider any Audit Wales National Value for Money Examinations & Performance Reports	**Ad hoc**	AW						

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Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2024/25					
			Quarter 1		Quarter 2		Quarter 3	Quarter 4
			16th April 2024	May 21st *Draft Accounts*	July 9th *Final Accounts*	10th Sept 2024	12th Nov 2024	18th Feb 2025
Total Items Scheduled (excluding preliminary items) -to be updated prior to each meeting			**10**	**18**	**17**	**14**	**13**	**15**
Audit, Risk and Assurance Committee Members to meet Independently with:								
External Audit Team	**BI**	Chair			√			√
Internal Audit Team	**BI**	Chair		√			√	
Local Counter Fraud Team	**BI**	Chair	√			√		

Lead Officer Key	
DofCG	Director of Corporate Governance
DofF&P	Director of Finance and Procurement
HofCF	Head of Counter Fraud
PPV	Post Payment Verification
HofIA	Head of Internal Audit
AW	Audit Wales
Chair	Chair

Frequency of Inclusion Key	
SI	Standing Item
AN	Annually
BI	Biannually
Quarterly	Quarterly

Schedule of Meetings Key	
√	Scheduled agenda item in FWP
D	Deferred from this agenda
√ **D**	Deferred Scheduled agenda item
W	Withdrawn from FWP
T	Transferred to another Committee
IC	Matter discussed In Committee

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CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	16 April 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Audit, Risk and Assurance Committee Annual Report 2023 - 24
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This paper presents the Audit, Risk and Assurance Committee Annual Report 2023-24, referred to as the Annual Report throughout this paper.

The Annual Report included as Appendix A is provided for endorsement prior to submission to the Board on 22 May 2024.

Cefndir / Background

Section 2 of Aneurin Bevan University Health Board's Standing Orders states that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

Asesiad / Assessment

The Audit, Risk and Assurance Committee has been established by the Board with the purpose of supporting the Board and Accounting 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 by:

- independently monitoring, reviewing, and reporting to the Board on the processes of governance, risk management and internal control in accordance with the standards of good governance determined for the NHS in Wales;
- advising the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further;
- Maintaining an appropriate financial focus demonstrated through robust financial reporting and maintenance of sound systems of internal control; and
- Working with the other committees of the Board to provide assurance that governance and risk management arrangements are adequate and part of an embedded Board Assurance Framework that is 'fit for purpose'.

Each Committee is responsible for developing an annual report for submission to the Board via the Chair within 6 weeks of the end of the reporting year, setting out its activities during the year and including the review of its performance.

The Board shall use the information from this evaluation activity to inform:

- The ongoing development of its governance arrangements, including its structures and processes;
- Its Board Development Programme, as part of an overall Organisation Development framework; and
- The Board's report of its alignment with the Welsh Government's Citizen Centred Governance Principles *"putting the citizen at the heart of everything and focusing on their needs and experiences; making the organisation's purpose the delivery of a high-quality service*."

The Annual Report seeks to provide a comprehensive evaluation of the business undertaken by the Committee throughout the 2023-24 financial year including any issues, and gaps in assurance that have required escalation to the Board.

Argymhelliad / Recommendation

The Committee is asked to:

- **CONSIDER** and **ENDORSE** its Annual Report 2023-24 prior to submission to the Board on 22 May 2024.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Failure to agree the reports would mean that the Health Board would not comply with Welsh Government and HM Treasury requirements.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The objectives will be referenced to the IMTP.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	Explained within the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable

• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item. Not applicable to the report, however, considerations will be included in considering how the business of the Committee aligns to the Well Being of Future Generations Act.

AUDIT, RISK AND ASSURANCE COMMITTEE

ANNUAL REPORT FOR 2023-24

March 2024

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FOREWORD

I am pleased to present the Audit, Risk and Assurance Committee's (the Committee's) Annual Report for the year ended 31 March 2024.

In this report we provide an overview of the work of the Committee and describe the steps taken to strengthen audit, risk management and assurance arrangements in the last 12 months.

The Committee has welcomed the main conclusion of the Auditor General for Wales' in the Structured Assessment for 2023 which concluded that Aneurin Bevan University Health Board: 'has broadly sound arrangements in place for governance, strategic planning and resource allocation and is making good progress in developing and refining its systems of assurance.' The report highlighted further opportunities for improvement in key areas, which will be monitored by the Committee.

The Committee has also acknowledged its role in overseeing the important work that is still being carried out in several areas to improve governance and assurance arrangements. This remains a key focus of the Committee's work in the year ahead.

Finally, I would like to express my personal thanks to all who contributed to the audit, risk, and assurance agenda over the last 12-months. Special thanks must be extended to Shelley Bosson, whose term as an Independent Member of the Health Board came to an end in March 2024, and Paul Deneen, who served on the Committee until August 2023. Both provided invaluable perspective, challenge, and support to enable the Committee to carry out its duties.

Diolch yn Fawr / Thank you.

Iwan Jones
Chair, Audit, Risk and Assurance Committee

INTRODUCTION

The Standing Orders[1] of Aneurin Bevan University Health Board (referred to throughout this document as 'ABUHB' or the 'Health Board') state that: "*The Board may and, where directed by the Welsh Government must, appoint Committees either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*". [Section 3]

The Term of Reference of the Audit & Assurance Committee (referred to throughout this report as 'the Committee') that applied in 2023/24 were approved by the Board in March 2022 (see **Appendix 1**). These were not changed during the reporting year, 2023/24.

The Committee formally adopted its Terms of Reference, following the Board's approval, on 23 March 2022.

The purpose of the Committee is to undertake scrutiny and review of matters related to audit, financial accounting, assurance, and risk management. In doing so, the Committee will support the Board and the 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.

The remainder of this report describes how the Committee complied with and satisfied the requirements set out within its Terms of Reference during the period 1 April 2023 to 31 March 2024.

2022-23 WORK PROGRAMME

ABUHB Standing Orders require the Director of Corporate Governance to produce an Annual Plan of Board business. This should incorporate formal Board meetings, regular Board Development sessions and, as appropriate, planned activities of the Board's Committees and Advisory Groups.

When the Committee's Work Programme (see **Appendix 2**) was agreed care was taken to ensure that this was aligned to its Terms of Reference and the requirement for the Committee to 'proactively seek information to gain assurance for itself and/or on behalf of the Board'.

[1] abuhb-model-standing-orders-reservation-and-delegation-of-powers-september-2023

The Work Programme is, however, a framework rather than a prescriptive agenda. This gives the Committee flexibility to identify changing priorities or any need for further assurance or information.

FREQUENCY OF COMMITTEE MEETINGS AND MEMBERSHIP

The Terms of Reference state that the committee should meet at least bi-monthly. During 2023-24, the Committee met six times virtually via Microsoft Teams

- 18 April 2023
- 23 May 2023 (draft annual accounts)
- 18 July 2023 (final annual accounts)
- 12 September 2023
- 28 November 2023
- 8 February 2024

The Terms of Reference state that the Committee should have four members; at the time of writing this report, the Committee consisted of the following Independent Members:

- Iwan Jones - Chair
- Richard Clark – Vice Chair
- Shelley Bosson
- Paul Deneen

Detail of the members and executive directors who attended these meetings is provided at **Appendix 3**.

Committee meetings were regularly attended by representatives from:

- Audit Wales; the Health Board's external auditor;
- Audit & Assurance Services NHS Wales Shared Services Partnership (Internal Audit) and;
- Local Counter Fraud Services

In 2023-24, the Committee received private briefings (without officers' present) from auditors and the local counter-fraud lead as below:

- Internal Audit (*November 2023*)
- External Audit (*April 2023 & February 2024*)
- Counter Fraud (September 2023)

COMMITTEE REPORTING ARRANGEMENTS

The minutes of Committee meetings are routinely submitted to the Board by way of an Assurance Report, these are included in an overarching Committee Assurance Report.

All Board papers can be accessed via the following link:
Audit Risk and Assurance Committee

COMPLIANCE WITH THE COMMITTEE'S WORK PROGRAMME

Among the key issues considered by the Committee during 2023-24, as outlined in the Committee's Work Programme, the following were also considered:

- Health Board Update Report on the Clinical Audit Plan
- Health Board Update Report on Clinical Audit Activity
- Audit Wales Orthopaedic Services in Wales: Tackling the Waiting List Backlog – National and Local Report
- Audit Wales Primary Care Follow-Up Report
- Audit Wales Stakeholder Perception Research Report

ASSURANCE AND IMPROVEMENT

The Committee reviewed and approved the audit strategies and plans for the auditors as listed below and received audit reports produced in support of them during 2023-24: -

- External Auditors, Audit Wales
- Internal Auditors, NWSSP Audit & Assurance Services

In approving the strategies and plans, the Committee ensured that they were robust and linked to the health board's risk profile.

Where reports received a less than reasonable assurance audit rating or where there were specific areas of concern, the appropriate Executive Directors were requested to attend Committee meetings. This process provided opportunities to discuss the reports more fully, and for the Committee to satisfy itself that the findings and recommendations raised in the reports were being addressed in a timely manner and implemented to address control weaknesses or compliance issues.

Certain reports were referred to other Committees of the Board for ongoing monitoring, for example reports relating to clinical governance issues were referred for further consideration by the Patient Quality Safety and Outcomes Committee.

EXTERNAL AUDIT – AUDIT WALES (AW)

The Auditor General for Wales is the statutory external auditor for the NHS in Wales. Audit Wales (AW) undertakes the external auditor role for the Health Board on behalf of the Auditor General.

The Audit Wales 2023 Structured Assessment work reviewed the Health Board's corporate governance and financial management arrangements, particularly the progress made in addressing the previous year's recommendations. Findings from the 2023 review were reported to the Committee in November 2023, prior to submission to the Board in January 2024.

Overall, the Audit Wales report stated: "**Overall, we found that while the Health Board governance arrangements are reasonably effective there is scope to provide clarity on both the impacts of actions set out in plans and actions taken to improve performance.'**

The report went on to say that:

- **Board transparency, effectiveness, and cohesion** – the Health Board's Board and Committee arrangements are reasonably effective; however, there are opportunities to improve the quality and timeliness of information to ensure effective oversight over the Health Board's key challenges.

- **Corporate systems of assurance** – the Health Board is making good progress in developing and refining its systems of assurance. However, it will need to effectively embed new arrangements across the organisation to manage the finance, performance, and quality risks it faces.

- **Corporate approach to planning** – the Health Board is developing a new long-term strategy that provides an opportunity to plan more sustainable services. There are reasonably effective arrangements for developing corporate plans; however, progress reports do not provide enough detail to demonstrate delivery is on track.

- **Corporate approach to managing financial resources -** The Health Board is facing significant financial challenges. Whilst there are reasonably effective financial planning and financial management arrangements, the Health Board needs to establish control over savings delivery to prevent the financial position from deteriorating.

Audit Wales was pleased to hear from Committee Members that they fully recognised the conclusions drawn and the key issues that required further improvement in the year ahead.

Copies of reports produced by Audit Wales can be accessed via the following link: Audit Wales Publications.

Each meeting of the Committee received a progress report from Audit Wales and during 2023-24 the Committee received two External Audit reports, relating to the Health Board's External Audit Plan.

- Audit Wales Orthopaedic Services in Wales: Tackling the Waiting List Backlog Local Report
- Audit Wales Primary Care Follow-Up Report

The following reports are expected to be received in Quarters 1 and 2 of the 2024-25 financial year: -

- Structured Assessment – Deep dive review of investment in digital (Q1)
- Follow up review of Quality Governance (Q1)
- Biodiversity and the Resilience of Ecosystems Duty (Q2)

INTERNAL AUDIT - NHS WALES SHARED SERVICES PARTNERSHIP (NWSSP)

During the first quarter of 2023-24, the Committee received Internal Audit reports from the schedule for 2022-23 as well as reports from the 2023-24 schedule, including management responses from the relevant Executive Director.

At the time of writing this report, **26** audit reviews have been reported to the Committee. These are detailed in the assurance rating sections.

The Committee will receive the following **five** final reports from the 2023-24 Internal Audit Plan at its April meeting. These are detailed in the assurance rating sections.

- Asset Management
- Risk Management & Assurance
- Follow-up of High Priority Recommendations
- Long Term Sickness Absence Management
- Unified Breast Unit at Ysbyty Ystrad Fawr

The three reviews listed below from the 2023 -2024 plan have been deferred.

- The Health & Social Care (Quality & Engagement) (Wales) Act
- Job Planning
- Allegations against Staff Policy

The following **16** reports form the 2023-24 audit scheduled will be presented at Committee meetings during Quarters 1 and 2 of the 2024-25.

- Savings Programmes
- Financial Controls
- Decarbonisation
- Medical Equipment and Devices
- Waiting List Management
- Directorate Review - Theatres
- Providing Care to Asylum Seekers
- Early Supported Discharge - Stroke
- Intra-site Patient Transfers
- Regional Partnership Board
- Maternity Action Plan
- Flexible Working (Advisory)
- LINC Programme
- Bevan Health and Wellbeing Centre
- Newport HWBC
- NHH Satellite Radiotherapy

The assurance sections that follow provide a summary of the scope of the Internal Audit Reviews that have been completed and received by the Committee during the financial year, April 2023 to March 2024.

Substantial Assurance

In the following review areas, it was reported that the Board could take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. The few matters that required attention were compliance or advisory in nature with low impact on residual risk exposure.

Cyber Security (2022 - 2023)
Executive Lead – Chief Executive Officer
The review sought to provide assurance that the organisation is working to improve its cyber security position, and that appropriate reporting is in place that shows the current status.

Unified Breast Unit at Ysbyty Ystrad Fawr (2023-2024)
Executive Lead – Chief Operating Officer
The audit sought to review the management arrangements in place to progress the Ysbyty Ystrad Fawr Unified Breast Unit – in the period after the prior audit, which was completed in December 2022

Reasonable Assurance

In the following review areas, it was reported that the Board could take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively.

Some matters required management attention in either control design or operational compliance and these had low to moderate impact on residual risk exposure until resolved.

Robotic Process Automation (2022-2023)
Executive Lead – Chief Executive Officer
The review sought to ensure that the organisation has an appropriate process in place to securely develop the Robotic Process Automation (RPA) function.

IT Strategy (2022-2023)
Executive Lead – Chief Executive Officer
The review sought to ensure that the organisation has developed an appropriate target operating model to enable to delivery of the Digital Strategy.

Financial Sustainability (2022-2023)
Executive Lead – Director of Finance and Procurement
The review sought to review the key financial management controls within Aneurin Bevan University Health Board including the development and monitoring of savings programmes required for financial sustainability.

Risk Management (2022 - 2023)
Executive Lead – Director of Corporate Governance
The review sought to provide an opinion of effectiveness of the risk management arrangements in place within a sample of divisions. To

complete this, we considered key sections of the Risk Management Strategy and Framework.

Monitoring Action Plans (2022-2023)
Executive Lead – Director of Corporate Governance
The review sought to review the arrangements in place within the Health Board for the logging, tracking and implementation of actions arising from external inspectorates (specifically Health Inspectorate Wales (HIW) and Health and Safety Executive (HSE).

Development of a Regional Radiotherapy Satellite Centre (RSC) at Nevill Hall Hospital (2022-2023)
Executive Lead – Director of Strategy, Planning and Partnerships.
The audit sought to review the delivery and management arrangements in place to progress the development of a Regional Radiotherapy Satellite Centre (RSC) at Nevill Hall Hospital, and the performance to date against its key delivery objectives i.e. time, cost, and quality.

Royal Gwent Hospital – Redevelopment & Expansion of Endoscopy Services (2022-2023)
Executive Lead – Director of Strategy, Planning and Partnerships
The audit sought to review the delivery and management arrangements in place to progress the Royal Gwent Hospital Endoscopy Redevelopment & Expansion of Endoscopy Services project, and the performance to date against its key delivery objectives i.e., time, cost, and quality.

Infection Prevention and Control (2022-2023)
Executive Lead – Director of Nursing
The review sought to assess adherence to organisational policies and the Health and Care Standards in Wales.

Integrated Wellbeing Networks (2022-2023)
Executive Lead – Director of Public Health
The review sought to provide an opinion on the Health Board's plan to further develop Integrated Wellbeing Networks across the region.

Dementia Services (2022-2023)
Executive Lead – Director of Nursing
The review sought to ensure that Aneurin Bevan University Health Board has an appropriate process for Dementia Services.

Contract Management (2022-2023)
Executive Lead – Chief Operating Officer
The audit sought to provide a review of the effectiveness of the management of operational contracts entered into by Aneurin Bevan University Health Board.

Mental Health Transformation (2022-2023)
Executive Lead – Chief Operating Officer
The audit sought to provide a review of the controls in place for the projects that support the transformation of mental health services within Aneurin Bevan University Health Board.

Bank Office and Temporary Workers (2022-2023)
Executive Lead – Director of Workforce and Organisational Development
The review sought to provide an opinion over the Bank Office and Temporary Workers process. As well as undertook a follow-up audit work on the process for contract and off-contract agency nursing.

IMPT (2023-2024)
Executive Lead – Director of Strategy, Planning and Partnerships.
The review sought to provide an opinion over the controls to ensure the delivery of the IMTP / strategic objectives.

Safeguarding (2023-2024)
Executive Lead – Director of Nursing
The audit sought to review the arrangements in place to ensure that the Health Board discharges its statutory responsibilities Safeguarding.

Clinical Coding (2023-2024)
Executive Lead – Director of Digital
The review sought to provide an opinion over the timely recording of Finished Consultant Episodes (FCE), in accordance with clinical coding standards.

Business Continuity Planning (2023-2024)
Executive Lead – Director of Strategy, Planning and Partnerships.
The review sought to review the arrangements that the Health Board has in place to maintain business continuity in the event of a critical incident, including how learnings from the Covid-19 pandemic have been Considered.

Integrated Performance Dashboard – Data Quality (2023-2024)
Executive Lead – Director of Digital
The review sought to assess the accuracy of data utilised within Integrated Performance Report (IPR) dashboard. In particular, focused on the accuracy of a sample of data used within the reporting of key metrics within the IPR dashboard i.e. that the source data utilised was consistent with the figures within the dashboard.

Stakeholder Engagement on IT Projects (2023-2024)
Executive Lead – Director of Digital
The audit sought to review the framework in place for stakeholder engagement on key IT projects.

Asset Management (2023-2024)
Executive Lead - Director of Finance and Procurement / Director of Digital
This review provided an opinion on the effectiveness of the Health Board's processes to create and maintain accurate and up-to-date records of its equipment assets. The review focused on the roll-out of Radio Frequency (RFID) tagging.

Risk Management & Assurance (2023-24)
Executive Lead – Director of Corporate Governance
This review sought to assess the effectiveness of the risk management and assurance arrangements in place within the Health Board, to ensure that strategic objectives are achieved. This review focused on the management of risks within the Digital Services Directorate

Long Term Sickness Absence Management (2023-24)
Executive Lead – Director of Workforce and Organisational Development
The review sought to determine compliance with the NHS Wales Managing Absence at Work Policy and whether the Health Board is acting promptly and managing the interests of all parties within the process of managing long term sickness absence.

Limited Assurance

In the following review areas, it was reported that the Board could take **only limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, were suitably designed and applied effectively.

More significant matters required management attention with moderate impact on residual risk exposure until resolved.

Bevan Health and Wellbeing Centre (2022-2023)
Executive Lead – Interim Director of Primary Care, Community and Mental Health
The audit sought to review the management arrangements in place to progress the Bevan Health & Wellbeing Centre.

Discharge Planning (2022-2023)
Executive Lead – Interim Director of Primary Care, Community and Mental Health
The review sought to provide an opinion on the discharge planning process of Aneurin Bevan University Health Board. It has focussed on the management and delivery of planned discharges and has included sample testing of patients admitted in during April and May 2022.

Facilities (2023-2024)
Executive Lead – Chief Operating Officer
The review sought to provide assurance over whether appropriate stock processes are in place and whether applicable controls within the process for allocating/approving bank shifts are effective.

Estates Condition (2023-2024)
Executive Lead – Director of Strategy, Planning and Partnerships.
The audit sought to evaluate the arrangements put in place by the UHB to identify and manage key risks associated with the existing estate and the implementation of resulting strategies to manage/mitigate the risk.

No Assurance

There were no audited areas that reported **no assurance.**

Assurance Rating Not Applicable

The following reviews were undertaken as part of the audit plan and reported or closed by correspondence without the standard assurance rating indicator, owing to the nature of the audit approach.

Clinical Futures - Care Closer to Home (2022-2023)
Executive Lead – Director of Strategy, Planning and Partnerships.
The review sought to provide Aneurin Bevan University Health Board with a consolidated summary of audit work reported as part of the 2022/23 Internal Audit Plan that covers the area of Clinical Futures – Care Closer to Home. Whether the Health Board is on track to implement its overall objective of Care Closer to Home.

Putting Things Right (2023-2024)
Executive Lead – Director of Nursing
To review sought to determine if there are alternative processes or approaches that can be adopted by the Health Board to improve the overall management of Putting Things Right.

Follow-up of High Priority Recommendations (2023-2024)

Executive Lead – Director of Corporate Governance
The review sought to assess whether high-level internal audit recommendations have been implemented and the completeness and accuracy of the updates provided to the Committee via the Audit Recommendation Tracking Tool (the 'Tracker')

MONITORING AND IMPLEMENTATION OF AUDIT RECOMMENDATIONS

At each meeting, the Committee received an update on the status of internal and external audit recommendations. At the February 2024 meeting, assurance reports for pre-2022 audit recommendations were submitted to provide a greater level of assurance regarding the work being undertaken to implement and close any legacy recommendations.

The development of simplified processes and strengthened relationships with service leads and executive directors has resulted in improvements in implementation of recommendations.

In April 2024, the Committee will receive an internal audit review of the monitoring and tracking of high-level recommendations, whilst this is an advisory report, there were a couple of findings with one medium-rated recommendation. The findings of the report will be used as a baseline to inform the areas of focus for 2024/25.

RISK MANAGEMENT

RISK MANAGEMENT FRAMEWORK

In May 2023, the Board reviewed its strategic risks to ensure they were consistent with its strategic objectives and ministerial priorities. This provided an opportunity to review the Health Board's risk management processes and update the Risk Management Framework, to enable the Health Board's risk management maturity to develop and progress.
The Committee received the revised Risk Management Framework, Policy, and Risk Appetite Statement for review and endorsement at its November meeting before submitting it to the Board for formal approval in January 2024.

The Risk Management Framework, Policy, and Appetite Statement provide assurance that the Health Board has robust risk management processes in place, with a clear structure of risk escalation via hierarchical risk

registers and assurance meetings to ensure delivery of operational and strategic objectives.

Since the refreshed approach and the establishment of the Strategic Risk Register, it has been determined that a greater emphasis on assurance mapping across the Three Lines of Defence Model to demonstrate assurance sources is necessary. Furthermore, reporting of the Corporate Risk Register will commence in 2024 to provide a holistic view of strategic and corporate risks (high-level operational risks).

To strengthen the internal control system, a system-wide assurance mapping exercise linked to the Quality Assurance and Performance Management Frameworks will be carried out to provide the Committee with the assurances it requires regarding its delegated responsibilities.

In late 2024, the Committee will receive an updated report on risk management that includes an assessment of the Health Board's risk management maturity.

Internal Audit completed its annual review of Risk management in March 2024. The purpose of the review was to assess the effectiveness of the risk management and assurance arrangements in place across divisions in order to ensure that strategic objectives are met. The review concluded with a reasonable assurance outcome and only one medium-rated recommendation, which is concerned with risk recording on the electronic risk management system, Datix, which is underway.

The development of a 'Once for Wales' risk management module is still in progress, with an implementation date postponed until the national group is satisfied that the system is fit for purpose and includes all the functions required for a robust and effective risk management system.

In the forthcoming financial year, 2024/25, the Corporate Governance Directorate will begin a period of communication and engagement with staff to launch the Risk Management Framework. To coincide with the launch, the Head of Corporate Risk and Assurance will increase visibility across the Health Board, raising awareness and providing staff with the knowledge and skills needed to incorporate risk management into their daily processes. This will be undertaken in a structured way, meeting with departments/directorates and divisions to begin embedding the Health Board's agreed-upon approach to risk management and the escalation process to mature the Health Board's risk management practices.

FREQUENCY OF RISK REVIEWS AND REPORTING

At each meeting of the Committee, an overview of the Strategic Risk Register is provided with detailed risk assessments of the risks. The Board then receives the overview of the Strategic Risk Register, and any areas of concern are highlighted, as appropriate.

COMMUNITY OF PRACTICE – RISK MANAGEMENT

The Risk Management Community of Practice (CoP) has been temporarily suspended while its Terms of Reference are reviewed, and its purpose determined.

The risk management group will be refreshed in 2024 to enhance its value, promote risk maturity, and share best practices for risk management and organisational learning.

SELF ASSESSMENT & EVALUATION

The Committee undertook its first mid-year self-assessment in September 2023 with the findings reported to the Committee in November 2023.

Overall, the Committee agreed it was discharging its responsibilities effectively, that reports were appropriate and provided the necessary detail for assurance, though this assurance can be reinforced through appropriate questioning**.**

There were four specific actions the Committee felt would add value to the Committee's Programme of Business, these have been considered and included in the draft 2024/25 Committee Programme of Business for consideration by the Committee.

The similarities in findings across the Committee structure from the mid-year self-assessments are being considered as part of the wider Board Business Improvement Plan that will be implemented throughout 2024/25.

The effectiveness of the Board's Business function is reported through the Annual Governance Statement, enabling a focus on the work undertaken with the Board's Committees, interconnectedness of the committees and escalation to the Board, as well as the culture between the Health Board and its auditors, regulators, and partners.

KEY AREAS OF FOCUS IN 2024-25

In the year ahead the Committee will continue to focus on those matters that will strengthen audit, risk, and assurance arrangements. The Committee Work Programme has been designed to ensure that in relation to all aspects of audit:

- internal financial control matters, such as safeguarding of assets, the maintenance of proper accounting records and the reliability of financial information;
- adequacy of disclosure statements (Governance Statement) which are supported by the Head of Internal Audit Opinion and other opinions;
- internal and external audit recommendations continue to be monitored, reviewed, and evaluated to ensure compliance and where compliance is not evidenced, clear, agreed rationale is provided;
- the policies and procedures related to fraud and corruption, and;
- that the system for risk management is robust in identifying and mitigating risks.

Thus, enabling the Committee to provide the Board with assurance that the risks impacting on the delivery of the Health Board's objectives are being appropriately managed.

The annual Committee Programme of Business will be reported to each meeting for discussion.

Hardcopies of the Work Programme can be obtained from the Director of Corporate Governance, Headquarters, St Cadoc's Hospital, Lodge Road, Caerleon, NP18 3ZQ.

CONCLUSION

This report provides a summary of the work undertaken by the Committee over the past 12 months and demonstrates how the Committee has complied with the Terms of Reference.

APPENDICES

- Appendix 1 – Audit, Risk & Assurance Committee Terms of Reference 2023/24
- Appendix 2 - Audit, Risk & Assurance Committee 2023/24 Work Plan
- Appendix 3 - Independent Members and Lead Executives Attendance at the Audit, Risk & Assurance Committee Meetings 2023/24

Appendix 1

Terms of Reference & Operating Arrangements

Document Title:	Audit, Risk & Assurance Committee Terms of Reference – 2023/24
Date of Document:	March 2022
Current version:	Approved
Previous version:	May 2021
Approved by:	Board
Review date:	March 2023

Version: Approved

Date: March 2022

1. INTRODUCTION

1.1 Section 2 of Aneurin Bevan University Health Board's Standing Orders (referred to in this document as 'ABUHB or the 'Health Board') Standing Orders provides that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the THB either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2 The Board has established a committee to be known as the **Audit, Risk and Assurance Committee** (referred to throughout this document as 'the Committee'). The Committee has been established in order to enable the scrutiny and review of matters related to audit, financial accounting, assurance and risk management, to a level of depth and detail not possible in Board meetings.

1.3 The detailed Terms of Reference and operating arrangements approved by the Board for this Committee are detailed below.

2. PURPOSE

2.1 The purpose of the Committee is to support the Board and Accounting 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 by:

- independently monitoring, reviewing and reporting to the Board on the processes of governance, risk management and internal control in accordance with the standards of good governance determined for the NHS in Wales;
- advising the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further;
- Maintaining an appropriate financial focus demonstrated through robust financial reporting and maintenance of sound systems of internal control; and

- Working with the other committees of the Board to provide assurance that governance and risk management arrangements are adequate and part of an embedded Board Assurance Framework that is 'fit for purpose'.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Audit, Risk and Assurance Committee will advise the Board and Accountable Officer on:

- the design, operation and effectiveness of strategic processes for risk management, internal control and corporate governance across the whole of the organisation's activities;
- the Annual Accountability Report, which includes the Annual Governance Statement;
- the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, and management's letter of representation to the external auditors;
- the planned activity and results of internal and external audit;
- adequacy of management response to issues identified by audit activity, including external audit's management letter;
- assurances relating to the management of risk and corporate governance requirements for the organisation;
- systems for financial reporting to the Board (including those of budgetary control);
- proposals for tendering for the purchase of audit and non-audit services from contractors who provide audit services; and
- anti-fraud policies, whistle-blowing processes, and arrangements for special investigations.

The Audit, Risk and Assurance Committee will also periodically review its own effectiveness and report the results of that review to the Board.

3.2 The Committee's workplan will include:

- a report summarising any significant changes to the organisation's strategic risks and a copy of the strategic/corporate Risk Register;

- a progress report from the Head of Internal Audit summarising:

  - ✓ work performed (and a comparison with work planned);
  - ✓ key issues emerging from the work of internal audit;
  - ✓ management response to audit recommendations;
  - ✓ changes to the agreed internal audit plan; and
  - ✓ any resourcing issues affecting the delivery of the objectives of internal audit;

- a progress report (written/verbal) from the External Audit representative summarising work done and emerging findings (this may include, where relevant to the organisation, aspects of the wider work carried out by the Audit Wales, for example, Value for Money reports and good practice findings);

- management assurance reports;

- reports (where appropriate) on action taken within the Board's Scheme of Delegation as regards:
  - use of single tender waivers;
  - extensions of contracts:
  - writing off of losses; or
  - the making of special payments;

- A report summarising progress in the implementation of audit recommendations, together with a copy of the Audit Recommendations Tracker;

and when appropriate the Committee will be provided with:

- proposals for the terms of reference of internal audit / the internal audit charter;

- the internal audit strategy;

- the Head of Internal Audit's Annual Opinion and Report;

- quality assurance reports on the internal audit function;

- the draft accounts of the organisation;
- the draft Annual Accountability Report which includes the Annual Governance Statement;
- a report on any changes to accounting policies;
- external Audit's management letter;
- a report on any proposals to tender for audit functions;
- a report on co-operation between internal and external audit;
- the organisation's Risk Management strategy;
- periodic reporting on Post Payment Verification Audits, and arrangements for managing declarations of interest and gifts and hospitality; and
- annual review of the Board's Standing Orders and Standing Financial Instructions, monitoring compliance and reporting any proposed changes to the Board for consideration and approval.

3.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

3.4 The Committee's programme of work will also be designed to provide assurance that:

- there is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;
- there is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Experience, Quality & Safety Committee;

- there are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's committees;

- the work carried out by key sources of external assurance, in particular, but not limited to the health board's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;

- the work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply; and

- the results of audit and assurance work specific to the health boards, and the implications of the findings of wider audit and assurance activity relevant to the HB's operations, are appropriately considered and acted upon to secure the ongoing development and improvement of the organisations governance arrangements.

Authority

3.5 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the health board relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and

- any other committee, subcommittee or group set up by the Board to assist it in the delivery of its functions.

3.6 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

Access

3.7 The Head of Internal Audit and the Engagement Partner/Audit Manager of External Audit shall have unrestricted and confidential access to the Chair of the Audit, Risk & Assurance Committee.

3.8 The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

3.9 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.10 The Committee may, subject to the approval of the LHB Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

4. MEMBERSHIP

Members

4.1 Membership will comprise a minimum of four (4) members, comprising:

Chair	Independent Member of the Board
Vice Chair	Independent Member of the Board
Members	Independent Member of the Board x 2
	The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge, and expertise.

Attendees

4.2 In attendance: The following members of the Executive Team will be regular attendees:

- The Accountable Officer
- Director of Finance, Procurement and VBHC
- Director of Corporate Governance

Other attendees will be:

- Head of Internal Audit
- Local Counter Fraud Specialist
- Representative of the Auditor General/External Audit

4.3 By invitation: The Committee Chair may extend invitations to attend committee meetings to the following:

- other Executive Directors; and

- other officials from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.4 The secretariat for the Committee will be provided by the Office of the Director of Corporate Governance.

Member Appointments

4.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the Chair of ABUHB - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.6 Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

4.7 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Chair of ABUHB.

Support to Committee Members

4.8 The Director of Corporate Governance, on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- ensure the provision of a programme of development for committee members as part of the Board's overall Development Programme.

5. COMMITTEE MEETINGS

Quorum

5.1 At least three members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.

5.2 Where members notify the Committee Chair or Committee Secretariat that they are unable to attend a meeting, and there is a danger that the Committee will not be quorate, the Chair can invite another independent member to become a temporary member of the Committee.

Frequency of Meetings

5.3 The Chair of the Committee, in agreement with Committee Members, shall determine the timing and frequency of meetings. However, meetings shall be held as a minimum on a **Bi-Monthly basis** (six times per year) and in line with the health board's annual plan of Board Business. However, additional meetings will be called, in agreement with the Chair of the Committee, if urgent business is required to be taken forward between scheduled meetings.

Openness and Transparency

5.4 Section 3.1 of ABUHB Standings Orders confirms the Board's commitment to openness and transparency in the conduct of all its business and extends equally to the work carried out on its behalf by Committees. The Board requires, wherever possible, meetings to be held in public. The Committee will:

- hold meetings in public, other than where a matter is required to be discussed in private (see point 5.6);

- issue an annual programme of meetings (including timings and venues) and its annual programme of business;

- publish agendas and papers on the Health Board's website in advance of meetings;

- ensure the provision of agendas and minutes in English and Welsh and upon request in accessible formats, such as Braille, large print, and easy read; and

- through ABUHB's website, promote information on how attendees can notify the Health Board of any access needs sufficiently in advance of a proposed meeting, e.g. interpretation or translation arrangements, in accordance with legislative requirements such as the Equality Act 2010 and Welsh Language Standards 2018.

Withdrawal of individuals in attendance

5.5 There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Director of Corporate Governance where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Committee shall resolve:

That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

In these circumstances, when the Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Committee in public session.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the audit and assurance. The Committee is directly accountable to the

Board for its performance in exercising the functions set out in these terms of reference.

6.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, joint and sub committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business;
- sharing of appropriate information; and
- appropriate escalation of concerns.

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.3 The Committee shall embed the health board's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, and the submission of Committee minutes and written reports;

- bring to the Board's specific attention any significant matters under consideration by the Committee;

- ensure appropriate escalation arrangements are in place to alert the Chair of ABUHB, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the health board.

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, e.g. Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate, e.g. where the committee's assurance role relates to a joint or shared responsibility.

7.3 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of further committees established.

7.4 The Committee shall provide a written annual report to the Board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

The requirements for the conduct of business as set out in ABUHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum
- Issue of Committee papers

The Board and Board Committee Handbook provides detailed guidance on the conduct of the Committees business.

9. CHAIR'S ACTION ON URGENT MATTERS

9.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. In these circumstances, the Chair of the Committee, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Committee - after first consulting with at least two other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

9.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring a decision.

10. REVIEW

10.1 These Terms of Reference shall be reviewed annually by the Committee. The Committee Chair will report any changes to the Board for ratification.

Appendix 2

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AUDIT, RISK & ASSURANCE COMMITTEE
PROGRAMME OF BUSINESS 2023/24

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 2023);
- 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 arrangement.

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24					
			18 April 2023	May 23 *Draft Accounts*	July 18 *Final Accounts*	12 Sept	28 Nov	08 Feb 2024
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 2023/24	Annually	Chair & Director of CG	√					√
Review of Committee Programme of Business	Standing Item	Chair	√			√	√	
Annual Review of Committee Terms of Reference 2023/24	Annually **(April)**	Chair & Director of CG	√					
Annual Review of Committee Effectiveness 2022/23	Annually **(September)**	Chair & Director of CG					√	
Committee Annual Report 2022/23	Annually **(April)**	Chair & Director of CG	√					

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24					
			18 April 2023	May 23 *Draft Accounts*	July 18 *Final Accounts*	12 Sept	28 Nov	08 Feb 2024
Corporate Governance, Risk & Assurance								
Receive assurance on implementation of the Governance Priorities set out within the IMTP 2022-25	Quarterly	Director of CG					√	
Review and report upon the adequacy of arrangements for declaring, registering and handling interests	Annually	Director of CG			√			√
Receive full report of all offers of gifts and hospitality as declared	Annually	Director of CG			√			√
Compliance with Ministerial Directions	Bi-Annually	Director of CG			√		√	
Compliance with Welsh Health Circulars (WHCs)	Bi-Annually	Director of CG			√		√	
Review of Standing Orders, Standing Financial Instructions and Scheme of Delegation	Annually	Director of CG						√
Audit Recommendations Tracking Report	Standing Item	Director of CG	√	√	√	√	√	√
Annual Review of Risk Management Strategy	Annually	Director of CG						√

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24					
			18 April 2023	May 23 *Draft Accounts*	July 18 *Final Accounts*	12 Sept	28 Nov	08 Feb 2024
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	√					√
Committee Risk & Assurance Report	Standing Item	Director of CG	√	√	√	√	√	√
Financial Governance and Control								
Report of the use of Single Tender Action	Standing Item	Director of FPV	√			√	√	√
Report of Losses and Special Payments *(May report will be included in the Accounts)*	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		√	√			

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24					
			18 April 2023	May 23 *Draft Accounts*	July 18 *Final Accounts*	12 Sept	28 Nov	08 Feb 2024
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			√			
Anti-Fraud								
Review of the Counter Fraud, Bribery and Corruption Policy	3-Yearly (Feb 2026)	Director of FPV	-	-	-	-	-	-

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24					
			18 April 2023	May 23 *Draft Accounts*	July 18 *Final Accounts*	12 Sept	28 Nov	08 Feb 2024
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 (Amanda Legge)				√		
Agree the Post Payment Verification Annual Workplan	Annually	PPV Manager		√				
Receive a Mid-Year update in respect of Post-Payment Verification Activity	Annually	PPV Manager					√	
Clinical Audit								
Ratify the Clinical Audit Plan 2023 – 2024 to be overseen by the PQSO Committee	Annually	Medical Director			√			

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24					
			18 April 2023	May 23 *Draft Accounts*	July 18 *Final Accounts*	12 Sept	28 Nov	08 Feb 2024
Receive an Annual Report 2023 – 2024 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						√

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24					
			18 April 2023	May 23 *Draft Accounts*	July 18 *Final Accounts*	12 Sept	28 Nov	08 Feb 2024
Agree the External Audit Annual Plan	Annually	Audit Wales		√				
Receive the 2023 Structured Assessment	Annually	Audit Wales					√	
Receive External Audit Progress Report 2023-24	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 / Deferred to future meeting
Received √	Received deferred Item
	Draft & Final Accounts

Appendix 3

Attendance at 2023-24 Audit, Risk and Assurance Committee Meetings: Independent Members and Lead Executives

Meeting Dates	18 April 2023	23 May 2023	18 July 2023	12 September 2023	28 November 2023	08 February 2024
MEMBERS						
Iwan Jones (Chair)	√	√	√	√	√	√
Richard Clark (Vice Chair)	√	√	Apologies	√	√	√
Shelley Bosson	√	√	√	√	√	√
Paul Deneen	√	√	√	No longer a member of the Committee		
OFFICERS						
Chief Executive	√	Apologies	Apologies	Apologies	√	Apologies
Director of Finance & Procurement	Apologies *(Representative attended)*	√	√	√	√	√
Director of Corporate Governance	√	√	√	√	√	√

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	16 April 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Internal and External Audit Recommendation Tracker
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The paper presents the Audit, Risk, and Assurance Committee (referred to as the Committee throughout the report) with an overview of all identified internal and external audit recommendations and current implementation status as at **31st March 2024.**

The paper also seeks to provide an update on recommendations that have progressed since the last reporting period, where a revised deadline has been proposed, recommendations that remain outstanding, and an overview of management action plans that have now been completed in their entirety.

Cefndir / Background

At its last meeting, the Committee agreed to transition to quarterly reporting if all longstanding (pre-date 2022/23 reporting year) Internal and External Audit Recommendations had either been completed or a proposed revised deadline with a robust action plan to complete recommendations had been provided.

Dashboard – Shows a whole picture of all live recommendations *Overdue and Not Yet Due reported on it Q4 **(Appendix 1**) We are committed to ensuring that there are no

long-standing overdue recommendations in the next iteration of the report that do not have revised deadlines.

Table 1 displays the number of overdue recommendations from audits conducted between the 2017-2021. Further details can be found at ***Appendix 2***

Table 1

All Longstanding (pre-2022) Overdue Recommendations as at 31 March 2024					
Year	**Priority Rating of Recommendation**				**Total**
	Low	Medium	High	N/A	
2017	**-**	**-**	**3**	**-**	**3**
2018	**-**	**-**	**-**	**-**	**-**
2019	**-**	**-**	**-**	**-**	**-**
2020	**-**	**-**	**-**	**4**	**4**
2021	**4**	**16**	**1**	**-**	**21**
Total	**4**	**16**	**4**	**4**	**28**

The data in Table 2 displays the number of overdue recommendations from audits conducted in the 2022/23 fiscal year. Further details can be found at ***Appendix 3***

Table 2

All Overdue Recommendations post 2022 financial year as of 31 March 2024					
Year	**Priority Rating of Recommendation**				**Total**
	Low	Medium	High	N/A	
2022	**12**	**24**	**4**	**2**	**42**
2023	**2**	**10**	**2**	**-**	**14**
2024	**3**	**15**	**14**	**-**	**32**
Total	**17**	**46**	**20**	**2**	**88**

The combined total for both tables **116** was the number of recommendations that required an update against, this is broken down in the main body of the report. Further details can be found at ***Appendix 2 and 3.***

The revised format for reporting recommendations that have passed their original and revised completion dates, as well as those that were closed during the previous reporting period, provides greater transparency and accountability about the status of recommendations, and allows the Committee to thoroughly scrutinise the information provided in order to obtain assurance of the implementation and progress of Internal and External Recommendations.

Asesiad / Assessment

Internal and External Audit Recommendation Tracking.

Since the previous reporting period, 30th December 2023, work has been completed to update the master tracker to include all Internal and External Audit Recommendations up until the last Committee meeting on 8th February 2024.

The Committee has been provided with data regarding the status of all overdue and completed recommendations as at the 31st of March 2024 for this iteration of the report.

Following the previous reporting period, which ended on 30th December 2023, several revised timeframes were agreed upon, leaving a residual position of **12** overdue internal and external recommendations. A further **104** recommendations were triggered as overdue in **Q4** (December–March). In total **116** updates against overdue recommendations were requested.

The position reported in Table 3 reflects the position following updates received against all overdue recommendations up to 31st March 2024.

Table 3

Overview of Recommendation Activity for Quarter 1 Reporting Period											
Lead Director	Chief Operating Officer	Director of Corporate Governance	Director of Digital	Director of Finance	Director of Nursing	Director of Public Health	Director of Strategy, Planning, and partnerships	Director of Workforce and OD	Medical Director	Director of Therapies and Health Science.	Total
IA Overdue	18	9	18	-	13	-	3	-	1	1	**63**
EA Overdue	-	1	-	-	1	-	-	1	-	-	**3**
Revised Deadline	17	10	17	-	11	-	3	1	1	1	**61**
Completed	**25**	**2**	**5**	**-**	**3**	**-**	**11**	**1**	**-**	**3**	**50**

NB: *The revised number of deadline(s) requested are included in the overdue figures.

The position reported in this paper reflects the position as at 31st March 2024 in which there are **116 overdue** internal and external recommendations, of which, **61 of the 116** have been assigned a revised timescale for implementation for approval by the Committee and **50** have been **completed.**

If the committee approves the **61** revised deadlines the residual overdue position will be as follows:

- **5** Internal
- **0** External

The data in the summary tables (4-5) provide a breakdown of overdue and completed recommendations by the year of the audit.

Table 4 below summarises the position as at **31st March 2024** by the year of audit, in relation to the **66 (61** of the **66** have revised deadlines) **overdue** (past the original agreed-upon implementation date) Internal and External audit recommendations.

Table 4

Internal and External Overdue Audit Recommendations (*Revised deadline requests)					
Year	**Priority Rating of Recommendation**				**Total**
	Low	**Medium**	**High**	**N/A**	
2017	-	-	**1** *(*1)*	-	**1** *(*1)*
2018	-	-	-	-	
2019	-	-	-	-	
2020	-	-	-	**3** *(*3)*	**3** *(*3)*
2021	**3** *(*3)*	**15***(*15)*	**1** *(*1)*	**-**	**19** *(*19)*
2022	**9** *(*9)*	**17** *(*14)*	**2** *(*2)*	**2***(*2)*	**30** *(*27)*
2023	-	**3** *(*2)*	**2** *(*2)*	-	**5** *(*4)*
2024	-	**3** *(*2)*	**5** *(*5)*	-	**8** *(*7)*
Total	**12** *(*12)*	**38** *(*33)*	**11** *(*11)*	**5** *(*5)*	**66** *(*61)*

(*Revised deadline requests)

The **61** audit recommendations with proposed revised timescales for implementation can be found at ***Appendix 4***

On the basis that the Committee endorses the **61** revised timeframes, **5** audit recommendations will remain **overdue** as at **31st March 2024.** Further detail can be found at ***Appendix 5***

Table 5 below summarises the position reported as at **31st March 2024** by the Year of audit in respect of **completed** recommendations. **50** overdue recommendations have been completed in this reporting period. Further detail can be found at ***Appendix 6***

Table 5

Internal and External Audit Completed Recommendations					
Year	**Priority Rating of Recommendation**				**Total**
	Low	**Medium**	**High**	**N/A**	
2017	**-**	**-**	**2**	**-**	**2**
2020	**-**	**-**	**-**	**1**	**1**
2021	1	1	-	-	**2**
2022	3	7	2	-	**12**
2023	2	7	-	-	**9**
2024	3	12	9	-	**24**
Total	**9**	**27**	**13**	**1**	**50**

Since this reporting period 31st March 2024, recommendations with deadlines in quarter 1 of the fiscal year 2024/25 would have become overdue. These will be updated in preparation for the next reporting cycle. For information, attached as ***Appendix 7*** is all recommendations Not Yet Due as at 31st March 2024.
Argymhelliad / Recommendation The Audit, Risk & Assurance Committee is asked to: • **NOTE** the position in respect of **5** overdue audit recommendations. • **NOTE** the position in respect of **50** complete audit recommendations. • **APPROVE** the revised timescales for the **61** Recommendations.

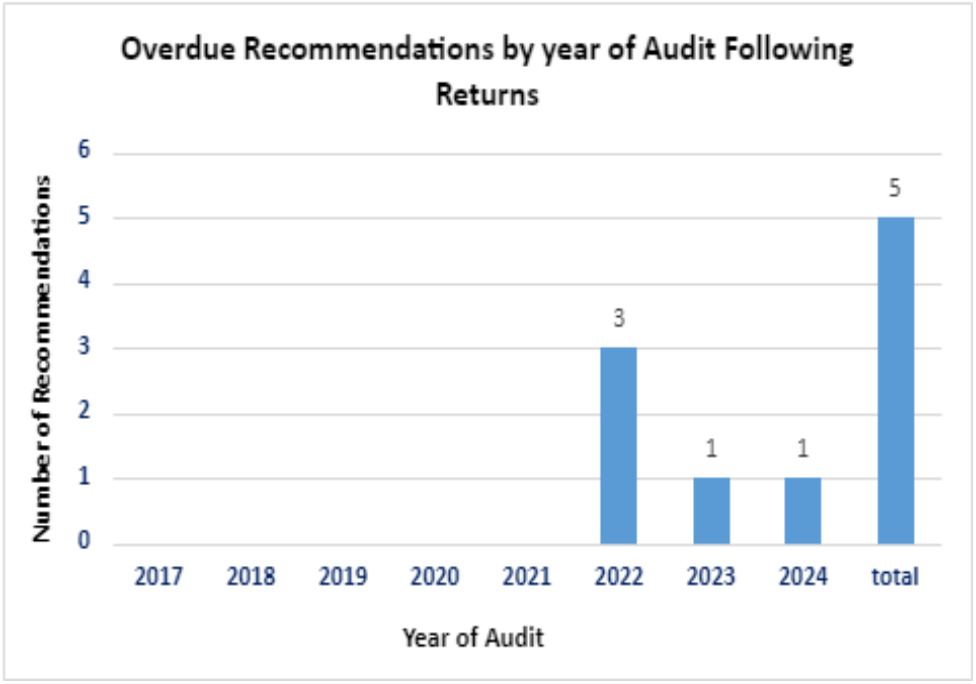
Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Risks associated with overdue recommendations will be captured locally and escalated to the strategic risk register if necessary.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Integral to the delivery of the IMTP
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

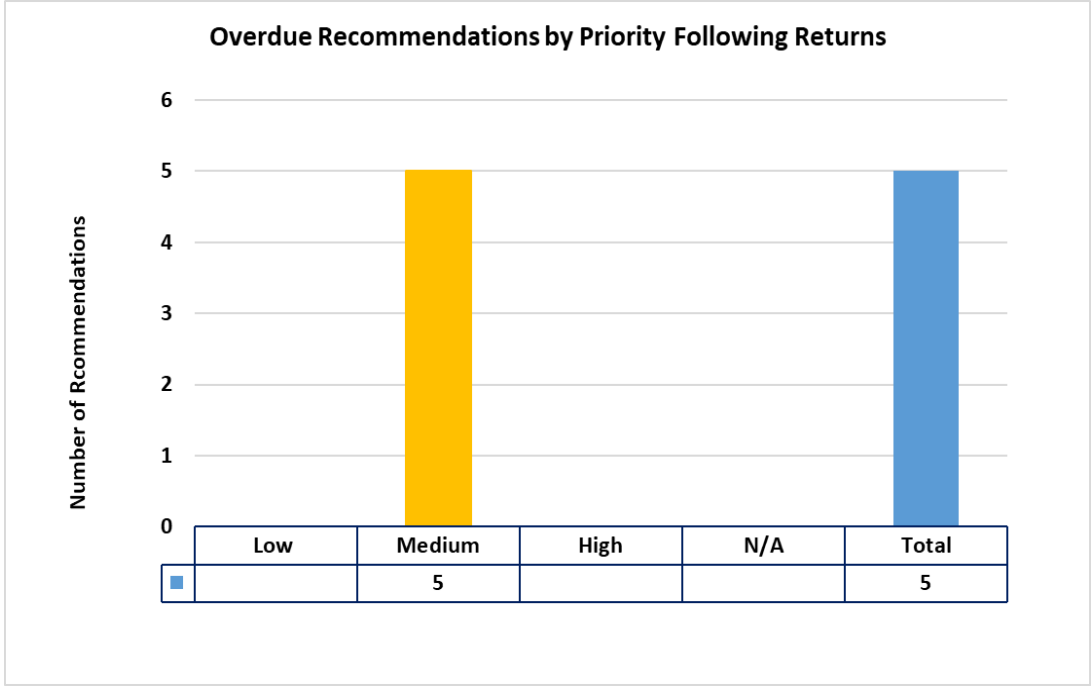
Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	All terms are explained within the body of the report.

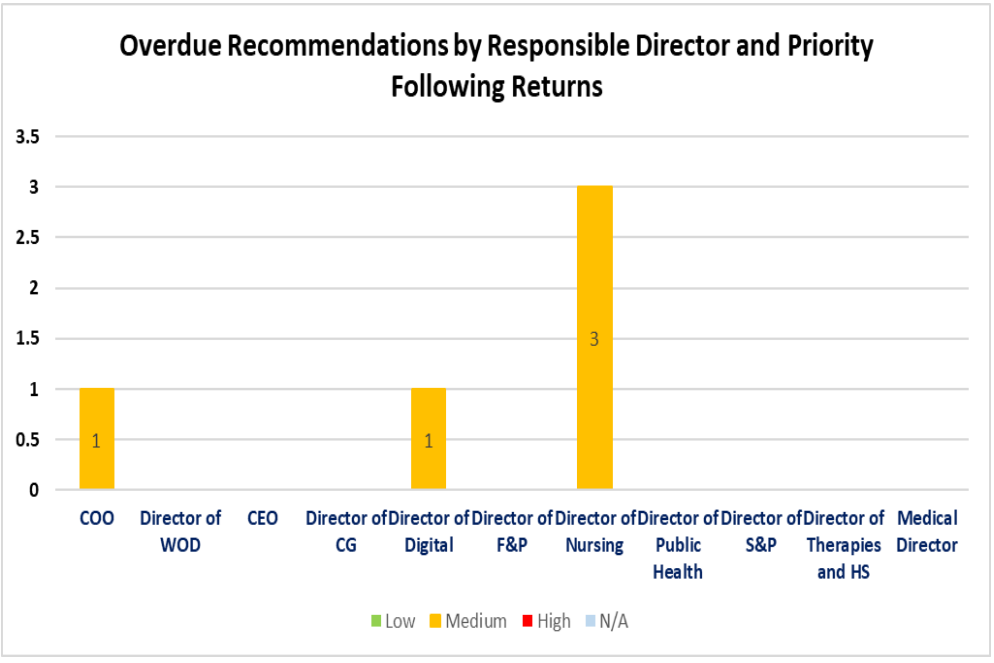
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA (Equality Impact Assessment) is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well, Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies

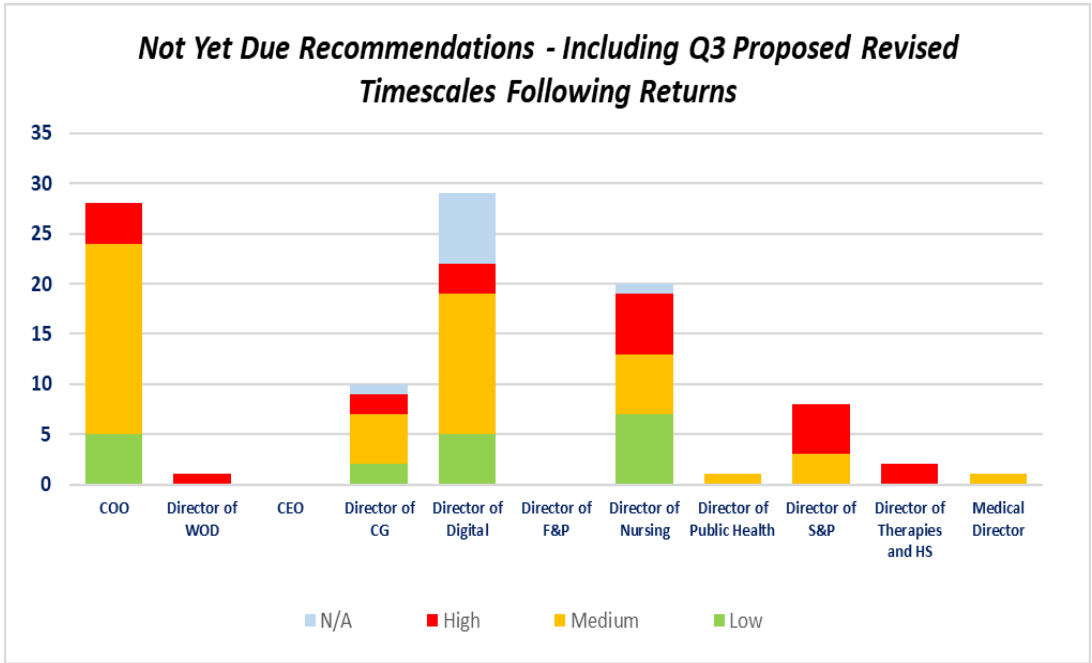
Accident ?
GIG
CYMRU
NHS
WALES
Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board







Overdue Recommednations by Priority	Low	Medium	High	N/A	Total
		5			5



Not Yet Due Recommendations by Priority	Low	Medium	High	N/A	Total
	19	49	23	9	100

Appendix 2: Pre 2022 Overdue Recommendations (Pre Q4 Update)

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Priority	Recommen-dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC	Final Report Deadline Status	Revised Deadline Status	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close/complete the recommendation?	Reporting Date
Internal	2017.00	Health and Safety (2017/18)	Limited	Director of Therapies and Health Science	High	R1	R1 The Health Board should develop a methodology / approach for establishing and undertaking an annual programme of workplace inspections. In particular, it should set out: How service areas / wards are selected for an inspection, including risk analysis, previous findings, incidents and Datix reporting; the approach to the inspection, including which health and safety areas are included. For example, there may be numerous priorities from one year to the next; methodology for undertaking the inspection, i.e. the process for completing one from start to finish; how assurance is provided to the sub-committees of the Board over how the programme of work is devised and that it is completed on schedule or otherwise; and findings from the workplace inspections are identified and acted upon.In addition, the Health Board should ensure that a programme of workplace inspections is developed and delivered in accordance with section 10.1 of the Occupational Health and Safety Policy. For example, the Health and Safety Committee may stipulate that all high risk areas are reviewed each year. Furthermore, if the programme is delivered late, then the Committee should receive assurances, together with an action plan for delivery to be returned to schedule.	An ABUHB health and safety monitoringmanual will be developed. This will include a two year plan which outlines the audit/inspection delivery programme.The manual, including programme willbe presented at the ABUHB Health and Safety Committee in March 2018 for approval. The anticipated start date of the monitoring is 1stApril 2018.Future monitoring of the health and safety audit/inspection compliance will be presented via Divisional dashboards with an overview being presented at the ABUHB Healthand Safety Committee.	30/04/2018	-70.89	31/03/2024		12/09/2023	Overdue	Overdue	**March 2023** - A programme of respiratory protection equipment (RPE) inspections has been developed and commenced in October 2022. The plan to inspect all in-patient clinical areas by March 2023 is approximately 95% complete. The inspections conducted by the Corporate Health and Safety Department are recorded via the AMaT system enabling the outcomes to be analysed & reported to relevant forums i.e. Divisional QPS meetings, Site Management groups, ABUHB Health and Safety Committee, QPS Operational Group etc. A programme of health and safety environmental inspections will commence in May 2023 and will target clinical areas. The programme will be carried out over a two-year cycle, commencing with the older estate or those that have been subject to significant change i.e. Royal Gwent Hospital and Nevill Hall Hospital. The inspections will be conducted by the Corporate Health and Safety Department and recorded via the AMaT system enabling the outcomes to be analysed & reported to relevant forums i.e. Divisional QPS meetings, Site Management groups, ABUHB Health and Safety Committee, QPS Operational Group etc. The Corporate Health and Safety Department are also planning the development of self-assessment inspection tools for wards and departments to complete their own localised health and safety monitoring. This will support a programme of health and safety monitoring across the Health Board.	There are no identified barriers to implementing the revitalised plan of health and safety monitoring. Resources that were not previously available within the Corporate Health and Safety Department have now been established to ensure a sustainable system of monitoring.	The risk will reduce as the programme of health and safety monitoring is implemented.	August 2023: Notes of the Health and Safety Committee Inspection reports via AMaT	31/03/2024
Internal	2017.00	Health and Safety (2017/18)	Limited	Director of Therapies and Health Science	High	R2	R2 The Health Board should ensure that each area has completed an up-to-date health and safety risk assessment, by a trained co-ordinator. The risk assessment process should be overseen by the Health and Safety team, to ensure that it is completed in accordance with the Occupational Health and Safety Policy.In addition, the Health Board should review and refresh the list of safety co-ordinators and continue to do so following the initial update.The Health and Safety team should provide assurance and regular updates to the Health and Safety Committee over the status of risk assessments.	The monitoring of local risk management systems, including risk assessments will be included in the audit/inspection programme.The status of risk assessments will be reviewed and compliance reported via a dashboard to the ABUHB Health and Safety Committee and relevant Divisional forums.Further consideration is required to the utilisation of software to record and manage risk within the Health Board.	30/04/2018	-70.89	31/03/2024		12/09/2023	Overdue	Overdue	**March 2023** - The Corporate Health and Safety Department have engaged with Divisions to ensure risks are recorded, monitoring and managed using the Datix system. This has improved the quality of health and safety risks on the system. The Corporate Health and Safety Department are reviewing all high risks (risk rating of 12 or above) recorded on the Datix system and where necessary support local managers to mitigate the risk. The programme of health and safety environmental inspections will support the identification and review of health and safety risks across the Health Board. Health and safety risks will be regularly reported to the ABUHB Health and Safety Committee to enable active monitoring. A revitalised education programme of health and safety risk assessment training has been approved and commenced in 2023. The register of risk assessors within the organisation has been reviewed and areas needing support will be prioritised for attendance at the risk assessment training.	The primary barrier to implementation would be lack of engagement from the areas / Divisions. Implementation of the new risk module in Datix Cymru could present a potential barrier.	The risk associated with the lack of health and safety risks will be reduced as areas engage with the risk assessment training and complete or update risks on the Datix system.	August 2023: Notes of the Health and Safety Committee Risk Assessment Training	31/03/2024
Internal	2017.00	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies and Health Science	High	R1	R1 Registers should be maintained for operational management of medical devices and equipmenton each ward and department, which should record relevant equipment details.The register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed.Each areashould ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record itupon theirregister. Discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded. Going forward, relocation of equipment, disposals, additions etc. should be updated promptly to ensure an accurate record continues.	The Health Board to consider investing in an overarching equipment database register with staff resources to ensure regular updating and management.	31/03/2018	-71.87	31/03/2024		08/02/2024	Overdue	Overdue	January 2024: Please see assurance report for full details. Nov 2022: This recommendation is monitored regularly via the Medical Devices Committee. The deadline is proposed to be extended due to Health Board ability to get around all of the equipment. We would suggest that the system is in place to track the assets however, further work is required to physically tag the equipment and ensure compliance and traceability.	January 2024: The technical aspects of attaching RFID tags and entering the related data into the Medusa, the Asset Register and the Paragon RFID databases for all equipment has restricted the people conducting the task to skilled and available EBME and Finance staff. Physically accessing equipment, which by design and necessity is mostly in utilisation on patients, has restricted the tagging operation to points of contact with equipment during EBME's routine equipment management operations, which run over a 12-monthly cycle. EBME have not had the resources to create the Customer Portal instructions and disseminate them. The software development between the 3 systems (Softpro Medusa, Ram Asset 4000 and Paragon RFID) is now operational. The unrelenting service pressures however means that there is still an extensive amount of work to visit every site and tag locations and equipment. This is still an ongoing project and work in progress. Assets are being tagged as and when we see them , however the process to blitz equipment tagging is restricted by the ongoing service pressures. There is also the ongoing restructuring of services/departments throughout our LGH's.	January 2024: The dominant risk factor related to this recommendation is of unbalanced investment in equipment, this is assessed as a having a current risk exposure level of 12 (high). The following mitigation actions are identified: · Work is in progress to assure that within the medical equipment and devices register, lists of medical equipment and devices located in our wards and departments are up-to-date and accurate. · Creation of user guide for the Medusa Customer Portal and provision of supporting training where necessary to aid ward and departmental managers in viewing and printing reports on their allocated equipment. · Completion of the roll-out of the Paragon RFID system will remove the need for regular routine manual verification of equipment that is allocated and deployed to work areas that are not sufficiently resourced to prioritise doing this manually. · Amendment to the Health Board's Medical Equipment and Devices Policy to improve clarity of the responsibilities and of ward and departmental managers on managing their allocated medical equipment and devices, and on delegation of this.	Whilst the aim is to tag all medical Equipment & devices throughout the HB hospitals we are focused on completing one major site. This being the GUH and to date out of 3242 assets listed on our database 1341 devices have been tagged, which represents 41.3% of assets on site at the GUH. In total we have RFID tagged over 4100 medical devices to date across our HB sites. Its difficult to commit to a completion date giving the ongoing service pressures, but this work is a daily ongoing process and when time allows we will undertake a blitz approach to RFID tagging the remaining devices, starting at the GUH.	31/03/2024
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R1	R1 The governance framework for IM&T / digital should be clarified and where control over aspects of IM&T has devolved to departments, there should be a process for these to feed into the relevant Committee to ensure oversight. Underneath the Committee the steering group remit and membership should be defined.	Agreed. The Health Board is establishing a new governance framework. Currently Informatics is reporting to the Audit Committee, the first report is scheduled for 8thApril. A Health Board governance framework is in development for informatics including exec oversight, investment and delivery. The management of the global pandemic has disrupted the planning work by 12 months but this is now re initiated. Recommendations arescheduled to be presented to Exec TeamQ1 , and Board in Q2;	30/06/2021	-32.95	31/01/2024	-1.97	28.11.2023	Overdue	Overdue	January 2024: The directorates new governance arrangements have been consulted and agreed internally. The Information Governance structure has been approved by the executive committee which will build on the well-established Governance & Assurance groups where there is strong engagement between the Information Governance team and Divisional leadership.				31/03/2024
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R4	R4 The risk identification process should be formally linked to the issue / event / problem management process in order to ensure that underlying risks are identified.	A review of risk management processes has commenced. The Health Board has appointed a Chief Nursing Information Officer/Clinical Safety Officer who will lead the project to align risk management processes from Programmes, design, Service Delivery, Health Records and Information Governance and Cyber Security to inform the new governance structure.	31/12/2021	1461.02	29/02/2024	1486.92	08/02/2024	Overdue	Overdue	January 2024: Work is underway to align the directorates existing risk management framework with the updated Health Board framework and will be complete by the end of February. Any digital issue, events and problems are managed using well defined best practice and roles are in place within Digital Service Delivery to support this. The new directorate framework will outline how operational risks identified through day-to-day support activities are managed using Datix as the single source of information. Strategic plan to incorporate cascade trainers into the training provision to increase compliance.				31/03/2024
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R5	R5 The Health Board should ensure greater links with divisions and the Informatics Directorate. The Informatics Directorate should be involved in the decision making process for all IM&T items.	Accepted. The CDO will present the recommended Target Operating Model to the HB which will include governance over Informatics as a Division and also departmental systems. Part of the framework will include decisions to procure and assurance processes not only for informatics division but informatics services owned outside. Part of adoption will help appraise strategic options in how the HB wishes to take this forward. Part of the SIRO objectives will set out the responsibilities for devolved asset owners and a performance management framework to identify risk and provide oversight. There is likely to be a resource impact in achieving this which will be subject to a business case.	31/03/2021	1452.00	31/03/2024		08/02/2024	Overdue	Overdue	Regular Divisional engagement meetings have been expanded to include Urgent Care leaving Mental Health & Learning Disabilities and Medicine to be implemented before the end of March 2024. Each Division will be provided with a 'Digital Buddy', a member of the Directorate Senior Leadership team who will chair the oversight meetings and will provide Divisions with a single point of contact for raising issues with the Directorate. As one of the key planning enablers the directorate participates actively in the annual planning process working with Planning to understand the needs of the service and align digital activities to those needs. The engagement and communication activities of the directorate will be summarised in a new Engagement & Communication Plan. Work is planned to restructure the directorate to enhance its strategic planning and engagement capability and new digital service request process will be implemented by February 2024 to funnel all requests for new services through the senior leadership team with additional appraisal undertaken of requests by the business analyst team with requestors to ensure requirements are understood, are properly documented, and have sufficient detail to enable prioritisation. The directorate recently had a substantial audit report from Internal Audit for its arrangements for stakeholder engagement. Nov 23: The TOF has been reviewed and the structure and operational model for Digital is being finalised, due to the requirement of an OCP it is antiicpated this will now be completed in approximately 6 months. August 2023: New governance group is under development to provide strategic oversight of digital initiatives, New Digital Service Request process is currently being finalised alongside a new Financial Control Procedure to provide governance and assurance over digital spend and initiatives. Business Partnership arrangements between Digital and the Divisions / Corporate Services is being planned. May 2023 - No additional TOF posts to be created pending new Director of Digital review March 2023 -Director of Digital will be reviewing the Target Operating Model once in post.				31/03/2024

Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R8	R8 An assessment of the changes needed to implement the Digital Strategy should be undertaken, and the benefits of the changes articulated, along with the consequences of no change. The Health Board should develop a single roadmap to help deliver the Digital Strategy.	As part of the review Informatics has accepted the need for P3O Portfolio management. This work is ongoing and with an initial focus to core Informatics Division activity but provides a framework for Health Board oversight and transparency. The portfolio approach will extend subject to Board approval to all information assets in a planned programme of work. This forms part of the recommendations to Execs in Q1 2021.	30/06/2021	1454.98	29/02/2024		08/02/2024	Overdue	Overdue	January 2024: A new digital service request process will be implemented by February 2024 to funnel all requests for new services through the senior leadership team with additional appraisal undertaken of requests by the business analyst team with requestors to ensure requests are understood, are properly documented, and have sufficient detail to enable prioritisation. A key component of this will be strategic alignment with the core local and national digital strategies. The Digital, Data & Technology sub-committee of the Finance & Performance Committee will provide an additional governance space for assurance of the work of the directorate by its Health Board stakeholders as well as the Executive. Progress has been made on the portfolio register to surface all digital work including new service requests and ICT projects. Resource & capacity modelling being developed along with business change tools to support service readiness for change. Internal audit will shortly be undertaking an audit of our portfolio arrangements in line with best practice. Currently the new Data Strategy is currently under development and associated strategies for ICT and Cyber Security are planned for the first quarter this year. The Health Board has commissioned CGI to undertake consultancy of on the future of the Electronic Health & Care record across the organisation and we would expect a report for this in the summer. These strategies will be brought together as an overarching summary Digital Strategy following these developments. Nov 23: The new digital service request process is nearing completion and will shortly be launched across the Health Board. The Digital governance committee will provide assurance on the digital plan and the updated digital programmes framework ensures benefits management will be ingrained on all projects. Aug-23: Progress being made on the portfolio register to surface all digital work including new service requests and ICT projects. Resource & capacity modelling being developed along with business change tools to support service readiness for change. May 2023 - Benefits audit carried out and substantial assurance awarded. Funding to fully establish the PMO not yet secured however a portfolio view of all digital service requests and transformation programmes has been				31/03/2024
Internal	2021.00	Gifts, Hospitality and Declarations of Interest	Reasonable	Director of Corporate Governance	Medium	R1	R1 The Health Board should add an additional section to the declaration of interests form detailing any additional action required to mitigate risk. These measures should be implementedand monitoredby the individual's line manager.b.The Policy and accompanying processes should be updated to support the changes required to mitigate the risk.	a.As identified, whilst there is adherence to the policy, the recommendation provides an opportunity to improve the mechanismswithin departments. To facilitate this the Health Boards ESR will be reviewed to determine how declarations can be digitally captured toenable improved conflictmonitoring and management.Where ESR may not be used (e.g. by Independent Members) then the manual form will be updated to reflect the recommended improvements. b.The policy and process documents will be updated to reflect the amendments.	31/10/2021	1459.02	31/03/2024		12/09/2023	Overdue	Overdue	January 2024: Assurance Report Completed. Arrangements for the declaring of interests, gifts and hospitality Included as a governance priority within the IMTP 2022-25 August 2023: Due to gaps within the corporate governance team this work has been delatyed. Recruitment has recently taken place with posts expected to be filled by November 2023. This work should therefore be completed in Q4, 2023/24				31/03/2024
Internal	2021.00	Gifts, Hospitality and Declarations of Interest	Reasonable	Director of Corporate Governance	Medium	R2	R2 The procedures for receiving and processing declarations made should be formalised and include:i.the use of a shared mailbox for all declarations;ii.details of the process for receiving and processing declarationsand the associatedtimescales;iii.details of due diligence to be undertaken on completed declarations;iv.timeframes for reminders to be issued in the event where previous declarations have been submitted; andv.details of any completeness checks to be undertaken to determine if there are missingdeclarations.	To facilitate all recommendationsthe Health Boards ESR will be reviewed to determine how declarations can be digitally captured and enabled toimprove receipt and management. This will facilitate improved recording across the organisation, allow automated reminders, and provide reports to Divisional managers for completion and adherence checks and missing declarations.In addition, where ESR may not be used (e.g. by Independent Members) then the manual form will be updated to reflect the recommended improvements.	31/10/2021	-28.92	31/03/2024		12/09/2023	Overdue	Overdue	January 2024: Assurance Report Completed. Arrangements for the declaring of interests, gifts and hospitality Included as a governance priority within the IMTP 2022-25 August 2023: Due to gaps within the corporate governance team this work has been delatyed. Recruitment has recently taken place with posts expected to be filled by November 2023. This work should therefore be completed in Q4, 2023/24				31/03/2024
Internal	2021.07	Occupational Health	Substantial	Director of Workforce & OD	Low	R1	The Health Board should consider:a)Automating key aspects of the processes, to reduce the workload for the Occupational Health Team. For example, auto-generation of emails / letters for referrals, self-selection of referral appointmentsby staff or a self-directed referral to an appropriate professional.b)Updating resilience / continuity plans to assist with increased demand in the future, to include reallocation of team members, setting up amended work schedules, reduced appointment slots, allocation of clerical staff to clinical staff to maximise clinic availability, overtimeoptions, re-focussing of service prioritiesand / or streamlining of processes to a bare minimumon a temporary basisetc.c)Engaging in any future All-Wales reviews of occupational health serviceswithin the NHS.	a.It is planned that the current management referral process will move from paper referral and Occupational Health response in letter format to an online referral system and subsequent report to managers in 2022. The service is currently part of an All Wales task and finish group developing this. Once implemented it should remove several administration stages of the current process. The recommendation for staff to be able to self–select would miss out the essential clinical triage process to allocate Occupational Health clinical staff resources appropriately. b.Occupational Health consistently review its skill mix and resources to meet the demands of the service. Through periods of higher administration demand for example Covid 19 PCR results and the annual Flu programme additional administrative hours are sourced. This reduces any impact on routine Occupational Health function. A detailed service review is planned for Quarter 2 in 2022 which will incorporate the recommendation of the Occupational Therapy scoping exercise which commenced on the 1st November and is planned to conclude on March 31st2022. Health function. A detailed service review is planned for Quarter 2 in 2022 which will incorporate the recommendation of the Occupational Therapy scoping exercise which commenced on the 1st November and is planned to conclude on March 31st 2022.	31/03/2022	-23.97	06/10/2023	-5.80	12/09/2023	Overdue	Overdue	Aug 2023: A new automated system OPASG2 is coming in on 20th September which will bring the following benefits in addition we are engaging with all Wales review and systems procurement. Applicants complete an online pre-employment health declaration – removal of paper forms! Integrated functionality between OPASG2 and the Trac recruitment system. Therefore, OH results update the applicant record directly in Trac. Transparency of applicant progress with timely updates visible in Trac such as an OH appointment booking. Reduced waiting times for Occupational Health Clearances	Aug 2023: Lessons learned from early implementers (Swansea)any any further potential dealys on an all Wales basis. Sep 2022 Awaiting decision regarding the new All Wales Occupational Health database. This has been put on hold until Spring 2023 . With regards OT implementation awaiting expressions of interest	Aug 2023: Executive team. Comprehensive training package Ongoing review of skill mix and resources to meet the deamands of the service .	Aug 2023: September/October 2023 for full implementation following procurement and implementation of the new data base.Ongoing evaluation of OT provision. Request extension to September/October 23. Autumn 2023 for full implementation following procurement and implementation of the new data base.	31/03/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R1	R1 Clarity should be sought over the roles and responsibilities of each party and a governance process established within Radiology that ensures the easy flow of work requests across team boundaries.	We have had a recent upgrade and the boundaries were clearer. The SLA sits with I.T and Radiology are the application owner. ABUHB Radiology internally request on service point if the department knows the server team need to undertake work. We will continue to do this.	01/03/2022	-24.95				Overdue		January 2024: Please refer to completed assurance report.		Targetted training is provided to teams in the meantime.		31/03/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R5.1	R5.1 The Board should introduce a completeness check to ensure that all requests received have been entered into WRIS.	Staff have SOP's and checks when putting forms on however human errors do occur without fully electronic requesting.	30/06/2022	-20.98				Overdue		January 2024: Please refer to completed assurance report.		Targetted training is provided to teams in the meantime.		31/03/2024

Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R4	R4 The Health Board should seek clarity over what maintenance tasks are expected and establish a process to ensure that these are completed.	There is a backup regimen in place, and DHCW has been notified of how this works.The point will be raised and the next WRIS SMB, and a request made for clarity over the expected database maintenance tasks and the frequency of these.	31/03/2022	-23.97				Overdue	January 2024: Please refer to completed assurance report. A database that the alerts and notifications is on is not supported by RadIS.	RadIS will not support this with the alerts and notifications query on the server still.	The database has been backed up by the server team		31/03/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R5	R5 The Board should investigate an electronic solution to uploading requests into WRIS.	Radiology have requested CWS to work with WCP for fully electronic requesting.	31/03/2022	-23.97				Overdue	January 2024: Please refer to completed assurance report. Aug 2023: The UAT has been passed and this is currently being looked at by informatics	Aug 2023: Required scoping, testing and development and planned for software development Needs to be agreed locally and product developed to suit ABUHB			31/03/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R6	R6 Password controls should be improved with an increased minimum length and the Board should reduce the default maximum attempts available.	Since this audit,this has now been altered and note it wasonlyone user with this many attempts all Administrators now have 5 attempts.	01/03/2022	-24.95				Overdue	January 2024: Please refer to completed assurance report. Nov 2023: currently trialling in primary care which has been succesful and is with software developments and informatics bussiness analysist to scope out as this is the selected solution from RISP.	Would need to staple in WCP ETR into CWS once the project has been scoped and timlined.	We have got checks for clinicians with similar names for obvious booking errors.		31/03/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R7	R7 The success of the use of the leavers list should be monitored to ensure that it works as anticipated and that all leaver accounts are removed on a timely basis.	We monitor this as much possible in Radiology. We have recently started receiving consultant leaver'slists from the Health Board and action these also.The success of the process will be tracked and evaluated to ensure it is working.	30/04/2022	-22.98				Overdue	January 2024: Please refer to completed assurance report. Aug 2023: Any leavers we will make inactive unless access is required for global imaging within PACS or cross boundry electronic requesting if they are still working within the Welsh NHS. We are still dependant on this list being provided.				31/03/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R8	R8 The Health Boardshould request that this logging function be developed and should consider feeding WRIS events into the SIEM.	The health board have raised this at DHCW CAB along with other health boards. This is with DHCW to develop it is not in any Live RadIS version currently.	31/03/2022	-23.97				Overdue	Currently with DHCW to develop,	Time and resource in RadIS. As well as pending RISP program may not help development.			31/03/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R9	R9 A formal disaster recovery plan for WRIS should be developed.	The Disaster recovery plan is to fail over to a mirrored system however, since the upgrade this needs to be re-visited and formally set out. ABUHB have a VMware environment where this is hosted.The Radiology departments have disaster recovery by using emergency packs in each department and a policy that explains how to use these emergency packs in a Radis downtime scenario.	30/04/2022	-22.98				Overdue	January 2024: Please refer to completed assurance report. Aug 2023: The BC plans in radiology are quite extensive and well practiced	Aug 2023: Time and resource in RadIS. As well as pending RISP program may not help development.			31/03/2024

Internal	2021.17	Corporate Governance: BAF	Reasonable	Director of Corporate Governance	Medium	R4	R4. We recommend that the Health Boarddevelops a periodic report commenting on compliance/ the effectiveness of the BAFprocessand reports this to an appropriate committee.	The Health Board accepts this recommendation and will incorporate a review of the effectiveness of the BAF into Board evaluation and committee self assessment processes.	31/07/2022	-19.97	31/03/2024		12/09/2023	Overdue		August 2023: Risk Management Stratgey and Board Assurance Framework processes under review. Revised strategy due to Board in Q4, 2023/24.			The Board reviewed and refreshed its strategic risks in June 2023, as part of that refresh the creation of a Strategic Risk Register (SRR) has been established (Board Assurance Framework [BAF]). The risks that form the SRR are aligned to the delivery of the IMTP and the Health Board's strategic and annual objectives. Regular reporting to the Board and sub-Committees of the Board has been in place since the refresh in June 2023. The Board receives the Risk Management and Assurance Report at every meeting as well as the Audit, Risk and Assurance Committee. Other sub-committees of the Board receive a Committee Risk and Assurance Report for the strategic risks for which it is responsible. In addition, any high-level operational risks that are included on the Corporate Risk Register (CRR) are reported to the relevant committee and to the Audit, Risk and Assurance Committee and the Board for oversight. This new approach ensures that the Board is sighted on all strategic and corporate risks that have the potential to impact delivery of the Health Board's objectives. In addition, the Risk Management Framework has been rewritten and a Risk Management Policy and Procedure has been developed to ensure greater transparency on the role of risk management, as well as how the risk management processes provide assurance to the Board that risks are being appropriately managed/mitigated. This was approved for use within the Health Board by the Board at its meeting on 24 January 2024. Work is ongoing with key stakeholders to triangulate performance and risk data to provide a coordinated report which will provide enhanced assurance to the Board of any potential risks that are on the horizon and how these are being managed. Furthermore, over the past few months all committees have undertaken their annual mid-year self-assessment; which will feed the annual Committee Effectiveness Report and the Annual Governance Statement. The information and	31/03/2024
Internal	2021.20	Medicines Managment	Reasonable	Medical Director	Medium	R2	R2.1 Management should review the Policy for the Management of Controlled Drugs and update where required.	The CD Policy is due for review during 2022/23. As in previous reviews a working group with representatives from Pharmacy and nursing will be set up to update the policy. A number of sections and standard operating procedures will be updated to make the policy more relevant and practical. This will support compliance with the policy. Controlled drug keys being held on their own may have been best practice. However, this may not be convenient on the wards. This could be removed in the updated version.The use of red pen on the wards is to make stock checks morevisible. The practicality of this will be reviewed.Keeping patients own CDs on a separate shelf may not always be possible. However, they should be clearly differentiated from ward stock.The policy will also include a description of the audit framework that will provide assurance the policy is being followed.	31/03/2023	-12.00	31/12/2023	-2.98		Overdue	Overdue	Update Aug 2023: The review date of the current policy is November 2023. Progress to review and update it was delayed to ensure compliance with the Welsh Government notification to ensure HB compliance with new Home Office licensing requirements for the Management of Controlled Drugs (this was issued late February 2023). Priority was given to the clinical areas where these licenses are required and to support the application process (ABSDAS services and community dental clinics). The new Home Office licensing arrangements will be included in the Management of Controlled Drugs Policy. The requirements within the Controlled Drugs Policy review identified several aspects that needed to be updated to reflect the changes in working practices. The revised operational procedures are being implemented prior to introduction of the new policy and are expected to be completed by the end August 2023. A revised Management of Controlled Drugs Policy has been drafted and is being reviewed across the Divisions and will provided to the Clinical Standards and Policy Group in November 2023 for approval.	Delay due to HMRC licencing requirements		ABUHB_Clinical_0552 Management of Controlled Drugs Policy_Issue 6	31/03/2024
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Low	R1	R1 For future iterations of the CAF there should be greater involvement of the system owners in the review of the responses.	ABUHB will ensure that in future iterations of the CAF there is greater involvement of System Owners	31/12/2022	1472.98	31/01/2024	1485.97	28.11.2023	Overdue	Overdue	January 2024: The Cyber Resilient Unit assessment is now scheduled for 22/01/2024. There was a pre assessment meeting arranged with the CRU before the new year to discuss scope and this included Information Asset Owners.There is strong engagement through our divisional assurance arrangements where regular meetings are held between the divisions and our cyber security team. This will be further strengthened with the Cyber Security Assurance Group which will be meeting for the first time this quarter. Nov 23: CRU assessment now scheduled for 22/01/2024. There will be a pre assessment meeting arranged by CRU in Nov/Dev to discuss scope and Digital will ensure this includes Information Asset Owners. Aug-23: CRU have provisionally provided a date for the next NIS CAF assessment process Oct 2023. As part of the engagement CRU have suggested a hybrid approach with onsite visits and interviews with systems owners. This is being piloted currently but is a process change from the previous assessment process undertaken in 2021				31/03/2024
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Medium	R2	R2 Management should ensure that records of discussions and information provided to and from the CRU are captured for future annual self-assessments.	Management will ensure that during any future self-assessments records of discussions and informationsupplied to the CRU will be captured and available for internal or external review.	31/12/2022	1472.98	31/01/2024	1485.97	28.11.2023	Overdue	Overdue	January 2024: In our assessment with the Cyber Resilience Unit in January we are discussing the documentation requirements and how we can ensure this audit recommendation can be satisfied going forward. Nov 23: CRU will outline what documentation/evidence they expect to be provided at the pre assessemnt scoping meeting prior to our January assessment. This is due to be held Nov/Dec 2023 Aug-23:CRU are piloting process changes to their approach from their initial NIS assessment undertaken in 2021, Future NIS CAF assessments will include evidence gathering ,recording and reporting as part of the new format.				31/03/2024
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Medium	R4	R4 The costs associated with the improvement actions should be assessed and reported to a relevant committee to enable awareness of the full picture and prioritisation of actions and funding.	The NIS Improvement Plan will be submitted through the relevant governance committee for senior Management review and sign off. Prioritisation of remedial actions and related costs will be assessed through ABUHB formal risk governance structureand relevant committees. Note ABUHB are currently implementing the recommendations of the Templar consultancy report which will create the Office of the SIRO and create a new governance frameworkto support Risk Management within the Health Board.	30/09/2022	1469.97	31/01/2024	1485.97	28.11.2023	Overdue	Overdue	January 2024: New Cyber Security Assurance Group will be meeting in January and will provide assurance through the Information Governance Sub-Committee including progress against the NIS action plan which has now been developed. Any associated costs will be captured as part of the Digital IMTP planning process and will form the basis of associated capital plans and potential bids to Welsh Government. Nov 23: New Cyber Security Assurance Group will be meeting in January and will provide assurance through the Information Governance Sub-Committee including progress against the NIS action plan which has now been developed. Any associated costs will be captured as part of the Digital IMTP planning process. AUG 2023: Awaiting next HBOTS meeting. May 23: work to commence shortly under SIRO Mar 23: Part of work programme that will be commencing from May under Rani Jan 23: Office of he SIRO has been established, implementation of supporting governance and structures are in progress allowing costs to be fully assessed and actions prioritised. Aug 22: The creation of the TOM and creation of the HBOTS is ongoing This will provide the risk management framework to allow costs associated to improvements to be managed and prioritised."				31/03/2024
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Medium	R5	R5 A formal reporting route for cyber security should be established to ensure that senior staff are aware of the position relating to cyber security and the risk description should be reviewed, with inclusion of the potential financial penalties relating to noncompliancewith NIS.	ABUHB are adopting recommendations of the Templar Report that will establish a formal risk governance and committee structure within the Health Board which will support Cyber Security Risk Reporting.5.2As part of the improvements suggested by Templar a new Cyber Risk Register will be developed. As part of development process account will be taken to include the financial penalties associated with noncompliance to NIS regulatory requirements into the assessment methodology and reporting.	30/09/2022	1469.97	31/01/2024	1485.97	28.11.2023	Overdue	Overdue	January 2024: The new Information Governance Sub-Committee will have its first meeting in February and will have a Cyber Security Assurance Group reporting too it which will have its first meeting in January 2024.Regularly report of cyber incidents, risk, awareness and training will be provided to the Finance and Performance Committee through reporting from the Information Governance Sub-Committee. Nov 23: New Information Governance Sub-Committee will have its first meeting in February and will have a Cyber Security Assurance Group reporting too it which will have its first meeting in January 2024 Aug 2023: Awaiting next HBOTS meeting. May 23: work to commence shortly under SIRO Mar 23: Part of work programme that will be commencing from May under Rani Jan 23: Regular cyber reporting is in place, currently this runs through Digital Delivery Oversight Board and to execs. This will change to HBOTS/SIRO once fully established Sept 22. The reporting route is being established following the appointment of the new SIRO. Aug 22: Work is ongoing to implement the TOM and supporting Risk management framework, A governance and Assurance Committee has been established this will report IG and Cyber risks identified at the GAGS through to the HBOTS . This will be supported by a corporate risk management methodology. The assessment methodology and risk scoring will capture the costs of non compliance to NIS and subsequent financial penalties that could be imposed."				31/03/2024

Internal	2021.24	Flow Centre	Reasonable	Chief Operating Officer	Low	R3	R3 The Flow Centre Team should develop key performance indicators to help improve the delivery of the service, manage key risks and to help develop staff.	With recent changes in clinical and operational leadership of the Flow Centre a focus will be on creating these key performance indicators (KPI) and stabilising the services as we recover from the impact of COVID. Create operational KPI for Pre-Hospital Screening. Create clinical KPI for Intersite transfer service. Review the clinical and operational model of the Flow Centre	30/09/2022	1469.97	31/12/2023	1484.95	12/09/2023	Overdue	Overdue	Mar 23 •Some KPIs have been created, reviewed each week at SLR and will form the basis of the Flow Centre Review currently taking place	Mar 23 Review being undertaken currently			31/03/2024
Internal	2021.24	Flow Centre	Reasonable	Chief Operating Officer	Medium	R4	R4. We recommend that the Flow Centre Team review and update the business continuity plan, where required.	The business continuity plan is being reviewed and updated currently.	30/06/2022	1466.95	31/12/2023	1484.95	12/09/2023	Overdue	Overdue	Aug 2023: In light of recent BC events we will review update and test this accordingly Mar 23 • The BCP has been created/updated and is due for a further review in light of recent IT risks and the joining of the Urgent Care Division	Mar 23 recent Divisional changes have meant that the BCP now requires further refinement however, orginal recommendation was implemented.			31/03/2024
Internal	2021.24	Flow Centre	Reasonable	Chief Operating Officer	Low	R4.1	R4.1 We recommend that the Flow Centre Team periodically test their business continuity plan and update it with learnings from the exercise(s).	A planned test of the business continuity plan will be initiated by the target date. An unplanned test of the business continuity plan will be initiated by the target date	30/10/2022	1470.95	31/12/2023	1484.95	12/09/2023	Overdue	Overdue	Aug 2023: In light of recent BC events we will review update and test this accordingly Mar 23 • This is on hold until we return to our call centre.				31/03/2024
External	2021.01EA	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Workforce & OD	High	R1	The Health Board should review the arrangements in place toensure that annual leave for all staff is accurately recorded and held centrally	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.	30/04/2022	1464.95	31/03/2024		28.11.2023	Overdue	Overdue	November 2023: Procurement completed. Draft Implementation plan being discussed with Divisional Directors. Roll out to commence in January 2024. Aug 2023: The roll out the newly procured workforce medical e-system will resolve the logging of annual leave centrally. Incremental implementation will progress once purchased. Current technical issues with procurement. If resolved implementation will commence October 23. Nov 2022 the roll out the newly procured workforce medical e-system will resolve the logging of annual leave centrally. Incremental implementation will progress over the next 9 months.	Aug 2023: Given current pressures on staff it is not felt that a interim system change of 12 months would be beneficial Cultural issue anticipated that it will take longer than June 2023 to realise in full. Given current pressures on staff it is not felt that a interim system change of 12 months would be beneficial Cultural issue anticipated that it will take longer than June 2023 to realise in full.	Aug 2023: Executive Team. Legal and Procurement advice	September/October 2023 for full implementation following procurement and implementation of the new data base.Ongoing evaluation of OT provision. Request extension to September/October 23.	31/03/2024

Appendix 3 - Post 2022 Overdue Recommendations Pre Q4 Update

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Priority	Recommen-dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC Comittee	Final Report Deadline Status	Revised Deadline Status	If closed and not complete please provide	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close/complete the recommendation?	Reporting Date
Internal	2022	CYP Continuing Care	Reasonable	Chief Operating Officer	High	R1	CloseHealth Board monitoring ofthe key risks facing the CCNS to ensure:•appropriate action continues to be taken; and•support is provided to the CCNS as required	1)Engagement with families and staff in a review of service models –utilising co-production and with a compassionate leadership lens explore options of "out of family home" models of care, which may meet needs of child/young person more effectively, optimise management of scarce resources and support retention of staff.2)Workforce review to identify skill mixedworkforceresource required to deliver safe service across the various linesof commissioned service e.g.Continuing Care, Special Schools, Children's Out Patients, Clinical/Care closer to home3)Business Case/Service Review to establish options of further efficiency and priority with theidentification ofdiscrete financialbudgetlinesto meet assessed and agreed service priorities4)Developing new roles/skill mix within the Children's Community Nursing Service to enhance service provision5)Partnership Board/Welsh Governmentrecommendation required to determine the prudent delivery of care described as ancillary and incidental care needs, and multi-agency responsibilities initsdelivery.This will aid the alignment of Value-Basedhealth care and Value-Based social care	31/03/2023	-12.00	31/12/2023	-2.98	12/09/2023	Overdue	Overdue		Aug 2023: Awaiting sign off of Bridgeview before we can engage with our families to explore out of home model of care. 2. Workforce review completed and skill mixed model identified. Awaiting sign off of Band 4 before implementation. 3. Business case submitted detailing risks of service reduction in each area. New financial envelope was estimated from a period of high vacancies, high sickness and complaints from families due to a reduction in their statutory respite. 4. Currently no scope to develop new or additional roles within the CCNS due to financial constraints, however skills mix model has been developed through the workforce work to enhance the skills and allow a "grown our own" model for sustainability in the future of the service. 5. Ongoing discussions due to social care and health interperating the recommendations differently.	Aug 2023: Bridge view sign off. Agreement and sign off of Band 4 Senior Health Care Support Workers. Differing interperation of goevernmenet recommendations from health and social care			31/03/2024
Internal	2022.1	Digital Benefits Realisation	Substantial	Director of Digital	Medium	R1	R1 - The Health Board should finalise the "front of house" process and enable a process for a holistic prioritisation of programmes.	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 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.	01/06/2023	1477.97	31/03/2024	1487.93	08/02/2024	Overdue	Overdue		Jan 24: A new digital service request process will be implemented by March 2024 to funnel all new service requests using a request form in our Seren ICT portal through the DDaT senior leadership team with additional appraisal of requests undertaken by the business analysis team with requestors to ensure requests are understood, properly documented and managed and have sufficient detail to enable prioritisation and scaling to enable prioritisation and progression in alignment with Health Board priorities. Nov 23: The new digital service request process is nearing completion and will be launched shortly across the Health Board. The digital governance committee will provide assurance on the digital plan and the updated digital programmes framework ensures benefits management will be ingrained in all projects. Aug-23: The Director of Digital has completed the review of the Front of House process and this is being finalised prior to approval by the Executive Committee in October which will include strengthening the financial and governance controls				31/03/2024
Internal	2022.1	Policies	Limited	Director of Corporate Governance	Low	R2	R2 The Health Board should not embed documents / files / forms etc. within a policy document hosted on the intranet. If a form is applicable, it should form part of the appendices or be referenced separately.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), the Quality Assurance process will be strengthened and implemented.	29/09/2023	1481.90	31/01/2024	1485.97	28.11.2023	Overdue	Overdue		November 2023: This is being actioned for newly approved policies and work will be undertaken to address this retrospectively as part of the review of the policy database. Work is underway to review the overarching policy framework and supporting guidance, this will include the requirements around embedded documents.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues	November 2023: Any new policies are checked for embedded documents prior to publication		31/03/2024
Internal	2022.1	Policies	Limited	Director of Corporate Governance	Low	R3	R3 The Health Board should consider the relevant Health and Care Standards when reviewing / updating a policy or other relevant documentation. An acknowledgement of this process should be included, together with the titles of the relevant Standards included.	The introduction of the Duty of Quality, under the Health and Social Care (Quality and Engagement) (Wales) Act 2020, will see the Health and Care Standards (April 2015) removed and replaced with Quality Standards 2023. As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), the introduction of the Quality Standards 2023 will be considered, and policy templates updated as they are reviewed/developed.	29/09/2023	1481.90	31/01/2024	1485.97	28.11.2023	Overdue	Overdue		November 2023: This will be included as part of the revised framework	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			31/03/2024
Internal	2022.1	Policies	Limited	Director of Corporate Governance	Medium	R4	R4 The Health Board, alongside recommendation 3.1 should consider automating the submission of a policy from the responsible owner, to ensure that a consistent submission format is adhered to.	An integrated electronic policy management system will be explored, learning from other health bodies, with an implementation plan developed to support the most appropriate system.	29/09/2023	1481.90	31/01/2024	1485.97	28.11.2023	Overdue	Overdue		November 2023: All policies are now managed via sharepoint, with an automated flagging and reminder system in place at 6 months prior to review, 3 months and when policy is overdue. A review of templates and submission process will be included in the revised policy framework being developed.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			31/03/2024

Internal	2022.1	Policies	Limited	Director of Corporate Governance	High	R5	R5 The Health Board should consider fully automating the reminder / management process of all relevant policies / documentation hosted on the intranet. This could be achieved through the use of Power Automate, Lists and other apps within Office 365. An automated work flow would undertake a periodic (e.g. weekly) check of all policies listed on the central spreadsheet that are overdue for review and issue automatic emails to the document owners. Following this, escalation to the respective Executive Director can also be completed automatically if documentation is still not updated in a timely manner. This would also allow for real-time reporting of documents that are overdue for review, to provide assurance to the respective Committees.	An integrated electronic policy management system will be explored, learning from other health bodies, with an implementation plan developed to support the most appropriate system.	29/09/2023	1481.90	31/01/2024	1485.97	28.11.2023	Overdue	Overdue	November 2023: Partially complete. Automated emails sent to policy manager advising of those policies due for review within 6 months/3 months and overdue in order to initiate reminders. Reporting to Committees to be established as paert of the review of the policies framework and implementation of a scheme of delegation for policy approval.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			31/03/2024
Internal	2022.1	Policies	Limited	Director of Corporate Governance	High	R6	R6 Once the Health Board has completed a review of all existing policy documentation, document reviews should be undertaken prior to the dates stated for review. Where exceptions remain, there should be an escalation process introduced to include the responsible Executive Director and potentially the Chief Executive Officer / Audit, Risk and Assurance Committee.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), the review and escalation process will be strengthened and implemented.	29/09/2023	1481.90	31/01/2024	1485.97	28.11.2023	Overdue	Overdue	November 2023: Automated email notifications in place to improve reminders to policy owners when policies are due for review. Escalation process to be clarified in revised policies framework.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			31/03/2024
Internal	2022.1	Policies	Limited	Director of Corporate Governance	Medium	R7	R7 The Health Board should complete a data accuracy review exercise of the policies and documents, alongside recommendation 2.1. Where data discrepancies exist these should be updated immediately to the correct value.	A review of the central base (881 documents) is underway, working with divisions, to review the status of each document and respective owners.	29/09/2023	1481.90	31/01/2024	1485.97	28.11.2023	Overdue	Overdue	November 2023: Review of database undertaken and checked against current policies. Executive leads have been issued with a schedule of policies assigned to them for review and confirmation of status.	November 2023: capacity to review policies given current operational and financial pressures.			31/03/2024
Internal	2022.1	Policies	Limited	Director of Corporate Governance	Medium	R1	R1 The Health Board should review the types of policy documents retained and hosted, to determine if each of them should adhere to the Policy, for example, departmental standard operating procedures to be managed entirely within the respective division. Alongside this review, the document owner should be determined to ensure the responsibility remains with the most appropriate individual.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), clarity will be provided on which WCDs are to be held centrally and which are to be managed within services and teams. A review of the central base (881 documents) is underway, working with divisions, to review the status of each document and respective owners.	31/03/2023	1475.93	31/01/2024	1485.97	28.11.2023	Overdue	Overdue	November 2023: Policy Framework currently under review. This will provide clear definitions of policies, procedures, guidelines and what constitutes an organisational policy. Scheme of delegation to be developed to support organisational policies which will be monitored by corporate governance, and departmental policies which will be led by individual departments (but held within the overall database)	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			31/03/2024
Internal	2022.1	Records Managment	Limited	Director of Digital	Medium	R5	R5 The need for records management storage places should be regularly reviewed to ensure that sufficient spaces are available for record keeping purposes.	This issue is to be raised with the All Wales Medical Directors Forum as Caldicott Guardians. The Data Protection Officer will raise this at quarterly meetings with the Medical Director and agree an action plan.	31/12/2023	1484.95				Overdue	Overdue					31/03/2024
Internal	2022.1	Records	Limited	Director of	Medium	R13	R13 All records should be formally tracked to ensure that they are	a.) The Business case for DHR phase 3 is in development, this will include the scanning of paper records to be available to view in CWS/cCube Portal negating the need for tracking.	31/12/2023	1484.95				Overdue						31/03/2024

Internal	2022.1	Managment	Limited	Digital	Medium	R13	retrievable when they are needed.	b.) Future phases for community, District Nursing, children's services and therapies are being planned and expedited and tracking will be implemented.	31/12/2023	1484.93				Overdue							31/03/2024
Internal	2022.1	Robotic process Automation	Reasonable	Director of Digital	Medium	R2	Benefits realisation should be established as part of the go-live for automated processes, with the relevant department being required to monitor and confirm the benefits.	Benefits realisation is identified and confirmed by relevant departments and this will now be formally monitored and confirmed by the governance board. This is in part contingent on a successful business case.	28/06/2023	1478.85	28/02/2024	1486.89	28.11.2023	Overdue	Overdue		Nov 23: Dependent on recruitment of of resources for RPA Aug-23: Service request forms and opportunity assessment form redesigned to provide better profiling of benefits. Process agreed by RPA Board for requesting service Finance BPA assurance of benefits before automations are agreed				31/03/2024
Internal	2022.1	Robotic process Automation	Reasonable	Director of Digital	Medium	R3	Consideration should be given to establishing a benefits sharing framework for cash releasing savings that would enable the RPA function to be self-sufficient.	This is not a unique issue to RPA but reflects the need for benefits realisation to include (when corroborated and confirmed) sharing of benefits including financial where this is the case. In order to mitigate the risk of priority based on ability to pay the process needs to be owned and curated at health board level rather than between departments. This recommendation will be considered in the case.	31/03/2023	1475.93	28/02/2024	1486.89	28.11.2023	Overdue	Overdue		Nov 23: Dependent on recruitment of of resources for RPA Aug-23: Service request forms and opportunity assessment form redesigned to provide better profiling of benefits. Process agreed by RPA Board for requesting service Finance BPA assurance of benefits before automations are agreed				31/03/2024
Internal	2022.1	Robotic process Automation	Reasonable	Director of Digital	Medium	R4	The Health Board should seek to complete recruitment and staff the RPA team accordingly.	A revised business case is expected to be submitted to Executive colleagues in Q4.	01/03/2023	1474.95	28/02/2024	1486.89	28.11.2023	Overdue	Overdue		Nov 23: Recruitment underway but experiencing delays in attracting the right level of candidates. Aug-23: RPA escalation SBAR presented to Exec Board in March 2023. 2 posts agreed.				31/03/2024
Internal	2022.1	Robotic process Automation	Reasonable	Director of Digital	Medium	R5	The Health Board should consider the purchase of additional robot capacity.	The business case for submission in Q4 provides an option also to increase capacity of automation.	01/03/2023	-12.98	28/02/2024	-1.05	28.11.2023	Overdue	Overdue		Nov 23: Dependent on recruitment of of resources for RPA Aug-23: RPA escalation SBAR presented to Exec Board in March 2023. Additional robot purchase not supported pending rebaselining of planned automations benefits				31/03/2024
Internal	2022.1	Robotic process Automation	Reasonable	Director of Digital	Medium	R6	Consideration should be given to increasing the level of ring fencing for specific robot time for time constrained processes as part of the ongoing development of the RPA service	The business case for submission in Q4 provides an option also to increase capacity of automation.	01/03/2023	-12.98	28/02/2024	-1.05	28.11.2023	Overdue	Overdue		Nov 23: Dependent on recruitment of of resources for RPA Aug-23: Peak day time capacity consumes all current robot capacity. Additional robots have been procured from non RPA budgets to support critical functionality. The RPA architect continues to reprofile activity to ensure automations are deployed optimally to allow additional automations not dependent on in hours working to be undertaken.				31/03/2024

Internal	2022.1	Robotic process Automation	Reasonable	Director of Digital	Medium	R7	The awareness of RPA and the change management process should be strengthened as RPA moves into an operational service. All services should be made aware of the requirement to notify Informatics of changes to any system that may interact with the robots.	Part of the transitional arrangements to operational services will be refined and robust service management arrangements. This is subject to a successful business case.	01/03/2023	-12.98	28/02/2024	-1.05	28.11.2023	Overdue	Overdue		Nov 23: Dependent on recruitment of of resources for RPA Aug-23: Transition to BASU will be undertaken when posts are appointed q3 2023				31/03/2024
Internal	2022.2	IT Strategy	Reasonable	Director of Digital	Medium	R2	The role of the CCIO and CNIO should be fully defined.	2.1a The CCIO currently has an AMD role profile. There has been discussions for some time in terms of role design and accountability with the CCIO MD CEO and CDO. A model role profile based on the Faculty of Clinical Informatics example has been agreed and is now being localised. The CNIO has a full role profile and agreed Job description	01/06/2023	-9.97	31/03/2024	0.00	08/02/2024	Overdue	Overdue		Jan 24: Future arrangements and resourcing to support the clinical engagement across the Health Board will be presented to the Exeuctive Committee in early March. This will create a formal structure of CNIO and CCIO's and a relauch of the Clinical Council. Nov 23: CNIO role established. Work continuing on formalising the CCIO role. Aug-23: CNIO aspects of this have been met				31/03/2024
Internal	2022.2	IT Strategy	Reasonable	Director of Digital	Medium	R3	Leads within divisions should be established to work with the CCIO / CNIO	The principle of Divisional Leads is accepted by the health board. The proposition now needs to be explored and defined in a proposal by the CCIO and CNIO to the Digital Delivery Oversight Board.	01/06/2023	1477.97	31/03/2024	1487.93	28.11.2023	Overdue	Overdue		Nov 23: Council not met for several meetings due to capacity issues and will need to be considered due to winter pressures so ToR will be looked at when we meet again Aug-23: Clinical Informatics Council in place and meeting scheduled every 6 weeks, however service pressures have resulted in over half the meetings this year cancelled. More formal job planning needed to release resources to attend	Lack of job profiling to support time to release clinical staff to attend			31/03/2024
Internal	2022.2	IT Strategy	Reasonable	Director of Digital	Low	R5	The skills development work should be formalised into a skills development plan	Agreed. The skills development plan is under development and apprenticeships are actively being explored with the support of Organisational Development colleagues. Informatics are now engaging with other Health Boards who report having commenced apprenticeship schemes	01/12/2023	1483.97	30/09/2024	1493.93	08/02/2024	Overdue	Overdue		"Jan-24: For Digital Specialist Procurement we have identified utilising Network 75, this combines a work placement and part time study as a route to a degree , the ethos of this scheme is for the directorate to grow their own talent for the future. •Analysis of current skills matched to Job Role has been largely completed and gap analysis is being undertaken. •Pre-requisite certification at Prince II foundation and ITIL v4 foundation desirable against all job roles. •Training Agreement has been implemented and is in use within the directorate but this needs consistency across all departments. •Budget restrictions have caused the removal of ring fenced training budget however many staff are taking advantage of non cost training (PLA etc) and being provided protected time for CPD. •Development of Learning & Develop Hub is making excellent progress •Need to agree on a skills management platform to implement "				31/03/2024
Internal	2022.2	IT Strategy	Reasonable	Director of Digital	Medium	R4	Work should be undertaken to embed the Clinical Informatics Council and encourage participation therein	Agreed. The CCIO and CNIO will revisit the membership and Terms of Reference for the Clinical Informatics Council which will be included as part of ??	01/06/2023	1477.97	31/03/2024	1487.93	28.11.2023	Overdue	Overdue		Nov 23: Council not met for several meetings due to capacity issues and will need to be considered due to winter pressures so ToR will be looked at when we meet again				31/03/2024
Internal	2022.2	Risk	Reasonable	Director of Corporate	Low	R2	The Health Board should clarify how Divisions will record risk in the	The Health Board is currently revising its Risk Management Policy which is expected to be presented for endorsement at the May	01/05/2023	10.98	31/03/2024	0.00	13/09/2023	Overdue	Overdue						31/03/2024

Internal	2022.2	Management	ble	Corporate Governance	Low	R2	meantime.	2023 Board meeting. Within the revised Strategy, refined guidance on capturing and recording of risks will be included.	01/05/2023	-10.98	31/03/2024	0.00	12/03/2023	Overdue	Overdue						31/03/2024
Internal	2022.2	Monitoring Action Plans	Reasonable	Director of Therapies and Health Science	Medium	R1	A SOP for how to manage and respond to HSE reports should be created. It should include, but not limited to: • how HSE reports are distributed to responsible staff within the Health Board; • who has designated responsibility for coordinating responses to HSE reports; • the escalation process for issues identified as part of HSE inspections; • who/which committee has responsibility for monitoring actions raised as part of the HSE reports and the process for doing this; and • when assurance reports should be produced and which committee should review them	The Health Board agrees with this recommendation. An SOP on the management of HSE reports will be developed and presented to the ABUHB Health and Safety Committee in May 2023	01/05/2023	-10.98	29/02/2024	-1.02	08/02/2024	Overdue	Overdue	January 2024: The development of an All Wales SOP on the management of HSE reports has stalled, therefore the Health Board have developed a Draft SOP which is currently awaiting approval August 2023: The development of an SOP on the management of HSE reports is being discussed at a national level via the All Wales Health and Safety Management Group. Following discussion at the natiional meeting in September 2023 an SOP will be prepared and shared with members of the Health and Safety Committee to share across the Health Board.				31/03/2024
Internal	2022.2	Discharge Planning	Limited	Director of Nursing	Medium	R7	We recommend that the Health Board continue to analyse the reasons behind re-admissions within a suitable period of time. Where themes and trends are identified that these are investigated further	The analysis of readmission rates is acknowledged as being problematic, as without clinical input at the time of readmission, our current systems are unable to differentiate between a readmission for a reason connected to a prior episode of care, or one that relates to a completely different clinical scenario. CHKS, which is the national benchmarking solution choice for Wales looks at the number of patients who have been readmitted regardless of specialty, consultant, diagnosis etc. This makes any analysis difficult to interpret or perhaps meaningless. The planning department is currently working with clinical teams to develop a number of meaningful measures to determine and understand readmission trends, and to identify where improvement is required. A number of data viewers have been developed and can provide 'bespoke' data by request. Moving forward, these measures will be included within the outcome measures and QPS insights. The Health Board has dedicated services to address frequent or 'high impact' service users that are working across Divisional Boundaries to provide alternative pathways. There is also a workstream focusing on patients at high risk of readmission supported by Lightfoot data and linked to goals 1 and 2 of the 6 Goals for Urgent & Emergency Care programme.	01/10/2023	1481.97	31/03/2024	1487.93	08/02/2024	Overdue	Overdue	January 2024: A review of the data and audit requirements for discharge is planned, the systems and processes have been revised and data and audit opportunities can now be reviewed including case review				31/03/2024
Internal	######	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	Medium	R4	Management should obtain signed lease agreements with relevant parties at the earliest opportunity	Agreed. The provision of signed lease is being actively addressed so that they are in place well before the planned occupation of the building.	01/06/2023	1477.97	31/03/2024	1487.93	08/02/2024	Overdue	Overdue	Jan 2024: Still being progressed by Shared Services Aug 2023: NHS Shared Services continue to progess the leases for GMS, Dental and Pharmacy accommodation			Aug 2023: Agreed leases	31/03/2024
Internal	######	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	Low	R6	Quantified, measurable and achievable targets should be set to appraise project benefits.	The Benefits register will be updated to reflect quantified targets as at the end of March 2023.	01/06/2023	1477.97	31/03/2024	1487.93	08/02/2024	Overdue	Overdue	Jan 2024: Has been discissed at Project Board but not finalised Aug 2023: This needs discussion at the newly constituted Project Board			Aug 2023: Updated BRP	31/03/2024
Internal	2022.2	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R5	At future projects Contracts should be executed prior to the commencement of works / duties.	Agreed -Future Projects Contracts will be signed prior to the commencement of works	01/03/2024	-0.98		-1487.93		Overdue		Derogations were signed off by the pervious Head of Operations. VT signed off design proposals and the scrutiny process required input from Shared Services to the technical design. Discussion could not place with the Linac Supplier until after FBC submission and this has subsequently led to a number of reviews of the Bunker Layouts.	Choice of Linac Supplier	This has not delayed project progress	Final sign off by Varian and VT	31/03/2024

Internal	2022.2	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Low	R5	At future projects All contracts should be dated	Agreed - Future Projects - Contracts will be dated.	01/03/2024	1486.95		0.00		Overdue			At this point in time the process for the provision of collectoral warranties has not required to be actioned as the relevant works have not be completed	None	N/A	None, CWs have so far not been required	31/03/2024
Internal	2022.2	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R5	All contracts over £100k in value should be signed by both the Chief Executive & Chair in accordance with the UHB's Standing Orders (Scheme of Delegation)	Agreed - Future Projects Contract Values exceeding £100k will be signed by the Chief Executive & Chair in accordance with UHB Standing Orders.	01/03/2024	1486.95		0.00		Overdue						31/03/2024
Internal	2022.3	Contract Mangement	Reasonable	Chief Operating Officer	High	R1	We recommend that Health Board management ensure that a contract management policy and guidance is developed, approved, issued and communicated to all relevant staff. It should incorporate the following: 1. guidance over the operational management responsibilities associated with contracts, including the management / identification of contract risks, performance monitoring, escalation of matters arising etc.; 2. template documents to record details of how individual contracts are to be managed e.g. responsibility for oversight and delivery. This is particularly important where the responsibility lies across different functions within the Health Board; 3. the All Wales Procure to Pay e-Manual, issued by NWSSP Procurement includes a section on implementation and contract management processes and provides information that should be aligned to any position developed by the Health Board; and 4. the Procurement Policy and Financial Control Procedure is updated to incorporate any relevant references as a result of the above changes.	A contract Management Policy is in the process of being developed and due to be drafted by the end of July 2023 for consideration and approval by end August 2023. The policy will make reference to standard documentation in order to standardise the approach to contract management across the Health Board, and form a FCP	01/08/2023	-7.97		-1487.93		Overdue			January 2024: A contract management Financial Control Procedure has been developed is is due to be presented to the Executive Board in the form of an SBAR. The final version is being retified by the Finance team before it goes to the Executive Board and then Audit Committee.				31/03/2024
Internal	2022.3	Contract Mangement	Reasonable	Chief Operating Officer	Medium	R1	The introduction of contract management guidance and policy should be supported by the roll out of an appropriate training programme to all relevant staff, to assist with the embedding of the agreed approach.	Once the Policy is finalised a training programme will commence for all contract managers delivered by the Head of Procurement and Assistant Head of Procurement, supported by the Divisional Finance Business Partners	01/12/2023	1483.97		0.00		Overdue			January 2024: A contract management Financial Control Procedure has been developed is is due to be presented to the Executive Board in the form of an SBAR. The final version is being retified by the Finance team before it goes to the Executive Board and then Audit Committee.				31/03/2024
Internal	2022.3	Contract Mangement	Reasonable	Chief Operating Officer	Medium	R2	We recommend that Health Board management ensure that: a. A repository of all signed contractual documentation is established to include: all contract schedules, framework agreements, service level agreements, call off orders etc. b. The repository is placed on a shared platform such that it is accessible to all relevant staff / stakeholders.	This is difficult as Procurement services who maintain the bulk of any contract documentation sits under NWSSP who have their own architecture within SharePoint which is not readily accessible to Health Board staff. It is proposed in the contract management policy that a contract management plan will be drafted between procurement and the responsible division/contract manager with information to be issued back to procurement at regular intervals. This will ensure that all contract documentation is kept in one place and is accessible by contacting the procurement team.	01/12/2023	1483.97		0.00		Overdue			January 2024: A contract management Financial Control Procedure has been developed is is due to be presented to the Executive Board in the form of an SBAR. The final version is being retified by the Finance team before it goes to the Executive Board and then Audit Committee.				31/03/2024
Internal	2022.3	Dementia	Reasona	Director of	Medium	R2	There should be a programme of work implemented, to undertake an assessment of the environmental suitability of wards that provide beds	This will be discussed at the In-Patient Hospital Group on 28th of	01/06/2023	1477.97	31/01/2024	1485.97	12/09/2023	Overdue	Overdue		UPDATE JULY 2023. Audit recommendations discussed at meeting. Agreement that a review of the in-patient action plan will be undertaken in September 2023. A dedicated inpatient workshop focussing on the All Wales Dementia Friendly Hospital Charter will				31/03/2024

Internal	2022.3	Dementia Services	Reasonable	Director of Nursing	Medium	R2	assessment of the environmental suitability of wards that provide beds for patients with dementia	June and confirm who leads on this	01/06/2023	1477.97	31/01/2024	1485.97	12/09/2023	Overdue	Overdue	Inpatient workshop focussing on the All Wales Dementia Friendly Hospital Charter will be held in November 2023. This will include a review of the resources required to undertale an environmental audit of in patient wards.				31/03/2024
Internal	2022.3	Dementia Services	Reasonable	Director of Nursing	Low	R2	Consideration should be given to digitalise the “this is me” document and use it as a dementia passport document. Also, make it as a live document which could be further used for home care and nursing home settings	This is me is not a mandatory/Once for Wales NHS tool. There are numerous documents/versions of information that would identify a person needs etc. We shall discuss this and other documents at the next Dementia Board and suggest that Workstream 2a and Workstream 3 leads on this recommendation and determine the feasibility of adding this document to the newly developed patient information portal.	01/06/2023	1477.97	31/01/2024	1485.97	12/09/2023	Overdue	Overdue	Nov 2023: Review of the outcomes from the National Audit of Dementia there is a recommendation for a relaunch of information to raise awareness of the diagnostic Code for Dementia on Clinical Workstation (136). The information will be added to the Internal Pulse web pages and shared through ABUHB e mail communication network.				31/03/2024
Internal	2022.3	Dementia Services	Reasonable	Director of Nursing	Medium	R3	It should be clearly defined and communicated in what circumstance alerts should be used. In addition, staff should be trained on how to add alerts to the system	We will review the training and electronic filing requirements for ‘alerts’ and ensure that clear messages are communicated to the relevant staff	01/07/2023	1478.95	29/02/2024	1486.92	28.11.2023	Overdue	Overdue					31/03/2024
Internal	2022.3	Dementia Services	Reasonable	Director of Nursing	Low	R3	Training should be provided to ensure a consistent approach for the electronic and paper records completion	We will review the training components and update where required, to ensure a consistent approach is adopted	01/07/2023	1478.95	29/02/2024	1486.92	28.11.2023	Overdue	Overdue	Nov 2023: Work stream 4 is the Hospital Dementia Friendly Charter, patient flow team have been invited to attend this meeting. There is also a audit perameter under the National Audit of Dementia. This will take a focused action as this aim is part if the wider hospitla admission and discharge work.	Nov 2023: This action needs to be part of the wider patient flow and discharge in ABUHB. Invites to the Dementia workstream 4 meetings will help us understand the challenges and solution and future measurements.	Nov 2023: Recorded and reviewing the membership of work stream 4 and action plan from the National Audit of Dementia.		31/03/2024
Internal	2022.3	Dementia Services	Reasonable	Director of Nursing	Low	R4	Consideration should be given to formally monitor (e.g. set KPIs) and report on • patients hospitalised outside of their catchment areas; and • moved from one hospital site to another one over their treatment time.	Workstream 5b (measurement) will consider appropriate KPI’s and will extend an invitation to the Patient Flow Team to be members of the workstream	01/08/2023	1479.97	29/02/2024	1486.92	28.11.2023	Overdue	Overdue	Nov 2023: Work stream 4 is the Hospital Dementia Friendly Charter, patient flow team have been invited to attend this meeting. There is also a audit perameter under the National Audit of Dementia. This will take a focused action as this aim is part if the wider hospitla admission and discharge work.				31/03/2024
Internal	2022.3	Dementia Services	Reasonable	Director of Nursing	Low	R4	Where operationally and clinically possible, a patient’s locality should be considered as part of the admission / transfer process.	Patient Flow Team to consider this specific aspect, linked to the developed KPI’s above	01/09/2023	1480.98	29/02/2024	1486.92	28.11.2023	Overdue	Overdue	Nov 2023: The Welsh language team are invited to the Dementia Workstream 4 Hospital Dementia group. The have a dedicated Pulse page to enable staff to access resources and information to support patients to communicate in the welsh language. the person centred team also have a dedicated e mail address and can signpost people to the the Welsh Language team.			Nov 2023: Pulse Welsh Language and engagement pages on the intranet as well as a Welsh Language team who we collaborate with closely.	31/03/2024

Internal	2022.3	Dementia Services	Reasonable	Director of Nursing	Low	R4	There should be easily available information / training for staff to ensure patients can communicate with Welsh speaking staff.	The Workstream 4 (Hospital Charter) to link with the Welsh Language Lead and Workforce and Organisational Development leads to identify the number of Welsh Speaking Staff, identify how we can better identify Welsh Speakers and ensure access to Welsh Speakers as part of our Person Centred Care Dementia Care work programme.	01/09/2023	1480.98	29/02/2024	1486.92	28.11.2023	Overdue	Overdue		Nov 2023: We have 15 wards who are adopting the VIP programme. We capture patient feedback and use patient experience to inform our improvments in care. recent example was the Anticipatory Grief learning module and Dementia Conference. The patient experience is an ongoing agenda item on our PCCT monthly team meetings. This information is included in QPS reports and annual reviews.			Nov 2023: We have 15 wards who are adopting the VIP programme. We capture patient feedback and use patient experience to inform our improvments in care. recent example was the Anticipatory Grief learning module and Dementia Conference. The patient experience is an ongoing agenda item on our PCCT monthly team meetings. This information is included in QPS reports and annual reviews.	31/03/2024
Internal	2022.3	Dementia Services	Reasonable	Director of Nursing	Low	R5	Local initiatives with success stories should be channelled and discussed at existing forums.	Patient Stories are used at MDT learning events, at Board, through the Quality and Patient Safety Operational Group (QPSOG) and Board. Discussions have taken place within the Person-Centred Care Team to develop a digital portal for all patient stories. Listening and Learning is reported at QPSOG. There are also early discussions around establishing a Community of Practice for patient experience to share learning and celebrate success/best practice (September 2023). The Dementia Specialist Practitioner through the VIPS work will be key to sharing best practice/success stories across all hospital wards.	01/09/2023	-6.95	29/02/2024	-1.02	28.11.2023	Overdue	Overdue						31/03/2024
Internal	2023	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	Medium	R1	A timeline plan for the path to the closure of the case should be prepared and shared with all persons involved in the case, in order that participants can plan and prepare for their input and schedule time to do so.	A review of the complaint process will be undertaken following the OCP process to realign Quality Patient Safety resourses to the Nusing Directorate. A new Quality Patient Safety Manager has been appointed who will be responsible for the complaints process. Since period of review the PTR, Legal and QPS teams are aligning under one structure, this will bring together enchanced knowledge and skills of the PTR regulations, legal tests and required timelines. The new structure will triangulate the whole complaint process, beinging improved quality and timeliness to concern responses.	31/03/2024	0.00		-1487.93		Overdue						31/03/2024
Internal	2023	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	Medium	R2	All investigation evidence should be attached to the complaint Datix record for ease of referance in the event of queries.	A review of the complaint process will be undertaken following the OCP process to realign Quality Patient Safety resourses to the Nusing Directorate. A new Quality Patient Safety Manager has been appointed who will be responsible for the complaints process. Since period of review the PTR, Legal and QPS teams are aligning under one structure, this will bring together enchanced knowledge and skills of the PTR regulations, legal tests and required timelines. The new structure will triangulate the whole complaint process, beinging improved quality and timeliness to concern responses.	31/03/2024	1487.93		0.00		Overdue						31/03/2024
Internal	2023	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	Low	R3	Complex complaint cases which under the regulations are permitted an investigation period of up to six months should be excluded from the 30 day breach statistics.	Welsh Government are currently reviewing PTR regulations.	31/01/2024	1485.97		0.00		Overdue						31/03/2024
Internal	2023	Putting Things Right; Final	Reasona	Director of	High	R4	Current barriers that are leading to poor resolution target and	An urgent review of any immediate barriers and quick winds will be undertaken. The PALS service was launched in November	31/12/2023	1484.95		0.00		Overdue						31/03/2024

Internal	2023	Final Advisory Review	ble	Nursing	High	R4	complience rates require identification and resolution urgently.	which will aim to resolve more complaints through early engagement with families	31/12/2023	1484.95		0.00		Overdue						31/03/2024
Internal	2023	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	Medium	R5	Complaint case analysis detail level should be sufficently granular, to provide learning to recipients and to prevent reoccurance.	Review of all QPS resourses being undertaken via an OCP will include learning. A review of divisional QPS structures and asurance mechanisms will be require followng OCP this will form part of a wider delivery plan for the Quality Strategy and a clear accountability frameowrk between the ursing Directorate and the Operational Divisons for QPS.	31/12/2023	1484.95		0.00		Overdue						31/03/2024
Internal	2023	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	High	R6	Actions to address the circumstances that have led to individual complaints and those that have been identifed to address complaint themes through boarder learning pathways should be captired in actions plans. The delivery of the plans should be monitored by appropriate oversight groups.	Review all QPS resourses being undertaken via an OCP which will include learning.	31/12/2023	1484.95		0.00		Overdue						31/03/2024
Internal	2023	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	Medium	R7	Actions to review the current structure throughout the Health Board mapped to the end to end process. Where gaps in or additional resourse requirements are identified these should be implemented to meet the requirements of the Health Board.	Review of all QPS resourses being undertaken via an OCP.	31/12/2023	1484.95		0.00		Overdue						31/03/2024
Internal	2023	Buisness Continuity Planning; Final Internal Audit	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R1.1	Business continuity plans and associated documentation should be completed for all service areas within the Health Board. The Health Board may wish to incorpoarte this process with the wider opeartional risk management processes. There needs to be an accountability and escalation routes if such plans/actions cards not completed.	Recommendation accepted - the requirement for business continuity plans is within the Policy and BG planing guidance. The emergency planning team have plans in place to further engage with specific service areas. The new intranet repository will provide further information and will provide further information and will be established to monitor the progress of plans. The newly established EPRR group will be well suited to be the forum for escalation.	31/01/2024	-1.97		-1487.93		Overdue						31/03/2024
Internal	2023	Buisness Continuity Planning; Final Internal Audit	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R1.2	Buisness continuity plans/action cards should be regularly tested, to ensure steps taken are the most effective. Following a continuity event test being completed, lessons learnt and updates to the documentation should be completed.	Reccomendation accepted - This is included within the policy and buisness continuity planning guidance. Outcome from exercises and tests can be added too the repository and monitored by the emergancy planning team and be avaliable to share with others for learning and via the EPRR group.	31/01/2024	1485.97		-1487.93		Overdue						31/03/2024

Internal	2023	Buisness Continuity Planning; Final Internal Audit	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R2	Buisness continuity should be promoted throughout the Health Board on a regular basis, to help raise awareness throughout all service areas	Recommendation accepted - Emergency planning promote buisness continuty on the intranet and to service leads, this wil be increased by quaterly updates on the intranet, using AB Pulse and with support from the communication team across other internal media platforms and through the EPRR group and the BC group.	31/01/2024	1485.97		-1487.93		Overdue								31/03/2024
Internal	2023	Buisness Continuity Planning; Final Internal Audit	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R2.1	The training resourse on ABUHB Sharepoint should be clearly signposted so staff know what the team delivers and what training they will need either on buisness continuity or major incident.	Recommendation accepted - promote and signpost services to the guidance viw the intranet and using the EPRR and BCM group. The repository will be in place by Dec 2023, easily accessed via the front page of AB Pulse and agree a weekly promotion of teh link with the comms team for the first month, and then quaterly as per R2	31/12/2023	1484.95		-1487.93		Overdue								31/03/2024
Internal	2023	Buisness Continuity Planning; Final Internal Audit	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R2.2	There should be regular monitoring of training delivery by the Emergency Planning Team to ensure staff have the appropriate knowledge.	This will be identified by through the tracker. The summary tracker will capture training, meetings, exersise and workshops, this wil sit within the repsoitory.	31/12/2023	1484.95		-1487.93		Overdue								31/03/2024
Internal	2023	Buisness Continuity Planning; Final Internal Audit	Reasonable	Director of Strategy, Planning & Partnerships	Low	R3	The Emergency Planning Team should undertake a "deep dive" of the information received on the Buisness continuity Resillence Day and implement any improvement actions required.	Recommendation accepted - The emergency planning team, divisons and directorates will continue to undertake debriefs following exercises and events to identify learning. Plans and actions card will be ammended according following this process. These will be shared via the BCM nad EPRR group as appropriate. The EP will develop a bespoke BC debrief workshop for Spring 2024	31/03/2024	1487.93		-1487.93		Overdue								31/03/2024
Internal	2023	Buisness Continuity Planning; Final Internal Audit	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R4	The Health Board should ensure that operational areas incorporate best practice, learning, lessons and other experiences from the pandemic within their buisness continuity plans.	Recommendation accepted - The BC guidenace incorporates debrief requirement to identify lessons to inform planning, this will be ammended to incorporate learning from the pandemic. An updated version will be shared with BC leads highlighting this requirement to be incorporated in new plans and current plans to be reviewed to ensure learning is included. This will be highlighted in all training and at the BC group meetings. This will also be monitored on the summary tracker reported inot the BC and EPRR group as part of the planned monitoring process.	31/12/2023	1484.95		-1487.93		Overdue								31/03/2024
External	2022.0	Structured Assessment	Not	Director of Corporate	N/A	R1	R1 Board and Committee agendas cause some meetings to overrun. The Health Board, therefore, should review Board and committee agendas to	Ongoing development of the Board's Assurance Framework and Risk Management Framework will enable the Board and Committees to ensure focus on priority, risk-based, areas by	01/09/2023	6.95	31/03/2024	0.00	28.11.2023	Overdue	Overdue		November 2023: The HOBB is undertaking a review of all board processes and procedures to secure greater consistency of approach and to ensure that all regulatory and statutory requirements are addressed though an action plan to improve board				31/03/2024

External	3EA	Assessment 2022	Rated	Corporate Governance	N/A	R1	ensure meeting business can be covered in the time available whilst also allowing for sufficient scrutiny and discussion.	exception, supported by risk-based workplans. The development of Board and Committee Etiquette and Conduct of Business will also support greater effectiveness of meetings.	01/03/2023	-8.93	31/03/2024	0.00	20.11.2023	Overdue	Overdue		and statutory requirements are addressed through an action plan to improve board buisness. This will include the timeliness of meetings and scope of papers for consideration.				31/03/2024
External	2022.03EA	Structured Assessment 2022	Not Rated	Director of Nursing	N/A	R3	R3 There is limited use of patient and staff stories at Board. The Health Board should consider how it can increase and maximise the benefit of patient and staff stories in Board and committees to help centre and focus meetings on the things that matter most, and to help triangulate this intelligence with formal agenda items.	A Digital Story Protocol for staff and patient stories is currently under development and once approved an electronic digital repository of stories will be created. Digital Story Telling training has been commissioned. The CIVICA Citizen Feedback System now allows people to leave narrated stories. A selection of these will be played at the start of every Board meeting. The Executive Team will agree a programme of staff and patient stories that help triangulate intelligence with formal agenda items.	31/03/2023	-12.00	31/12/2023	-2.98	12/09/2023	Overdue	Overdue		June 23: A Patient Experience & Involvment Strategy has been developed which includes Digital Patient Narratives and Stories. A patient story has been presented at a Board Development Session and PQSOC this year. Update July 2023: The Digital Story Protocol is drfated but is now being revised due to recent decisions to support 'in-person' patient experiences at Board. To date, a patient story has been played at each Board during 2023. Additionally, digital stories are being used at listening and learning events and development days. There is all Wales discussion around a digital toolkit. The CIVICA system is being rolled out with a specific focus on supporting teams with training to retrieve their own data. Patient verbal narratives are not yet on the system. The first CIVICA report will be presented at Executive Team in September 2023.				31/03/2024
Internal	2024	Estates Condition - Jan 2024	Limited	Director of Strategy, Planning & Partnerships	Low	R3	The Health Board should assess the sufficiency of reserve funds to address backlog at the handover of PFI buildings.	Agreed - The PFI agreements include a minimum level of expected condition for buildings &/or equipment to be maintained for operational capability. Regular management review ensures these contract terms are being met. When handover of PFI assets are expected escalated arrangements are put in place to assess the level of condition. The following PFI schemes exist: NHH LLanwenarth day surgery unit, which has now gone through a process of 'buy back' of the headlease. The operating lease will end in 2024, the process of negotiating a settlement figure has agreed the equipment and building condition expected at handover date. Chepstow Community Hospital PFI is in advanced discussions with the owner/provider relating to the PFI end in Feb 2025. Negotiations relate to the building being in a Condition B status at time of any handover, a condition review has been commissioned and the PFI provider has agreed to implement improvements to meet condition B. Energy PFI (Honeywell) in NHH which ends in December 2026. This PFI is about to undergo a readiness assessment through WG for PFI end but does not relate to buildings and only relates to plant. Monnow Vale – ends in March 2036	31/03/2024			0.00		Overdue							31/03/2024
Internal	2024	Estates Condition - Jan 2024	Limited	Director of Strategy, Planning & Partnerships	High	R4.1	Management should review and implement effective reporting of Estates condition/ backlog across the UHB's Committee structure e.g. outcomes against targets, funding risks, risk exposure etc.	Agreed. The Board's Finance and Performance Committee has delegated responsibility to seek assurance that arrangements for the performance management of capital, estates and support services related standards and systems are sufficient, effective,and robust, including: • the monitoring of capital and estates related objectives and priorities as set out in the Board's IMTP and Annual Priorities; • the monitoring of compliance with Health Technical Memorandums; • the monitoring of progress in delivery Board-approved capital business cases and programmes of work. This is set out in the agreed Terms of Reference for the Committee. Work is ongoing to develop workplans for each Committee for the 2024/25 financial year and this will consider the role of each Committee and the work required to fulfil the respective Committee's obligations. In 2023/24, work was undertaken to revise the Capital and Capital Project governance arrangements which encompassedbacklog maintenance within the discretionary capital programme. These governance arrangements were reported to the Board's Partnerships, Population Health and Planning Committee in July 2023	31/03/2024			0.00		Overdue							31/03/2024
Internal	2024	Estates Condition - Jan 2024	Limited	Director of Strategy, Planning & Partnerships	Medium	R4.2	Management should update the Estates Strategy (or equivalent) for continued relevance to estates condition as appropriate.	Agreed – this forms part of forward work plan for the Planning, Population Health and Partnerships Committee.	31/03/2024			0.00		Overdue							31/03/2024
Internal	2024	Estates Condition - Jan 2024	Limited	Director of Strategy, Planning & Partnerships	High	R6	The effectiveness of escalation and oversight of capital and estates related risks should be reviewed, notably as to the Board and relevant committees.	At its meeting in January 2024, the Board approved its Revised Risk Management Framework which set out the revised hierarchy for risk management within the organisation, alongside an agreed Risk Appetite Statement. In-line with this Framework, the Head of Risk and Assurance will work with the Divisional Director of Estates & Facilities to review the risk management arrangements in place, ensureing appropriate escalation reporting from service to Board level.	31/01/2024			0.00		Overdue							31/03/2024

Internal	2024	Stakeholder Engagement on IT Projects	Substantial	Director of Digital	Low	R1	A template should be developed in order to record all workshop attendance	Standardised templates for Steering Groups and Workshops will be developed b the Buisness change Team and will be incoorporated into the Project Management Framework.	31/03/2024			0.00		Overdue							31/03/2024
Internal	2024	Stakeholder Engagement on IT Projects	Substantial	Director of Digital	Low	R2	Consideration should be given for a single record to track attendance at project and programme boards.	A meeting attendance tracker will be created and will be implemented for use by all project boards.	31/03/2024			0.00		Overdue							31/03/2024
Internal	2024	Facilities - Jan 2024	Limited	Chief Operating Officer	High	R1.1	Management should set out what information should be formally monitored at each site, at an operational level. This information could include, stock balances, stock usage, footfall, food waste etc. To support this, consistent procedures should be implemented across the Health Board andshould be accessible to all staff.Once embedded, spot checks should be carried out on the stock management at each site and the results of these checks should be reported to the monthly Facilities meeting.	ACCEPTED. The following steps will be taken to address the issue: Standard Operating Procedures will be developed to detail each step of the new process. These processes will be shared with staff and be made accessible	29/02/2024	1486.92		0.00		Overdue							31/03/2024
Internal	2024	Facilities - Jan 2024	Limited	Chief Operating Officer	High	R1.2	Management should set out what information should be formally monitored at each site, at an operational level. This information could include, stock balances, stock usage, footfall, food waste etc. To support this, consistent procedures should be implemented across the Health Board andshould be accessible to all staff.Once embedded, spot checks should be carried out on the stock management at each site and the results of these checks should be reported to the monthly Facilities meeting.	ACCEPTED. The following steps will be taken to address the issue: Each member of staff involved in the management or delivery of stock takes will be provided with training detailing the correct methods to use.	31/03/2024	1487.93		0.00		Overdue							31/03/2024
Internal	2024	Facilities - Jan 2024	Limited	Chief Operating Officer	High	R1.3	Management should set out what information should be formally monitored at each site, at an operational level. This information could include, stock balances, stock usage, footfall, food waste etc. To support this, consistent procedures should be implemented across the Health Board andshould be accessible to all staff.Once embedded, spot checks should be carried out on the stock management at each site and the results of these checks should be reported to the monthly Facilities meeting.	ACCEPTED. The following steps will be taken to address the issue: Monthly stock takes wil take place at each site following the process set out in the Health Boards Financial Cotrol Procedure: Stores and Stocks.	31/03/2024	1487.93		0.00		Overdue							31/03/2024
Internal	2024	Facilities - Jan	Limited	Chief Operating	High	R1.4	Management should set out what information should be formally monitored at each site, at an operational level. This information could include, stock balances, stock usage, footfall, food waste etc. To support this, consistent procedures should be implemented across the Health	ACCEPTED. The following steps will be taken to address the issue: Stock usage (patient orders and retail sales) will be monitored to track stock balances, and to ensure that provision orders align	29/02/2024	1486.92		0.00		Overdue							31/03/2024

Internal	2024	2024	Limited	Operating Officer	High	R1.4	Board andshould be accessible to all staff.Once embedded, spot checks should be carried out on the stock management at each site and the results of these checks should be reported to the monthly Facilities meeting.	with all menus and match forecasted demand. Monthly Synbiotix data to be sent to senior FM managers of non-compliance with agreed provisions.	29/02/2024	1486.92		0.00		Overdue						31/03/2024
Internal	2024	Facilities - Jan 2024	Limited	Chief Operating Officer	High	R1.5	Management should set out what information should be formally monitored at each site, at an operational level. This information could include, stock balances, stock usage, footfall, food waste etc. To support this, consistent procedures should be implemented across the Health Board andshould be accessible to all staff.Once embedded, spot checks should be carried out on the stock management at each site and the results of these checks should be reported to the monthly Facilities meeting.	ACCEPTED. The following steps will be taken to address the issue: Local management teams will report on stock levels, food waste (production, unserved, and damaged stock) at the monthly Facilities Management Team meeting (chaired by the Head of Facilities	31/03/2024	0.00		0.00		Overdue						31/03/2024
Internal	2024	Facilities - Jan 2024	Limited	Chief Operating Officer	High	R1.6	Management should set out what information should be formally monitored at each site, at an operational level. This information could include, stock balances, stock usage, footfall, food waste etc. To support this, consistent procedures should be implemented across the Health Board andshould be accessible to all staff.Once embedded, spot checks should be carried out on the stock management at each site and the results of these checks should be reported to the monthly Facilities meeting.	ACCEPTED. The following steps will be taken to address the issue: Facilities Managers will provide assurance at monthly Facilities Management Team meetings that all provision orders match forecasted demand	29/02/2024			0.00		Overdue						31/03/2024
Internal	2024	Facilities - Jan 2024	Limited	Chief Operating Officer	High	R1.7	Management should set out what information should be formally monitored at each site, at an operational level. This information could include, stock balances, stock usage, footfall, food waste etc. To support this, consistent procedures should be implemented across the Health Board andshould be accessible to all staff.Once embedded, spot checks should be carried out on the stock management at each site and the results of these checks should be reported to the monthly Facilities meeting.	ACCEPTED. The following steps will be taken to address the issue: The Head of Facilities will consider the potential benefit of software to improve the efficiency, effectiveness and accuracy of stock management processes. Options to be presented to the Divisional Director for decision	31/03/2024	1487.93		0.00		Overdue						31/03/2024
Internal	2024	Facilities - Jan 2024	Limited	Chief Operating Officer	High	R2	Management should implement a consistent approach to stock ordering. This process should be based on current footfall and patient numbers, provisions already in stock and the quantities required per portion from the All-Wales recipes. Management should then complete monthly spot checks to ensure the process is being adhered to. Stock ordering should then be reported at the monthly Facilities meetings to ensure senior management have view of any issues.	ACCEPTED. The following steps will be taken to address the issue:Actions set out in agreed management action for matter arising R1.1-1.7	31/03/2024	1487.93		0.00		Overdue						31/03/2024
Internal	2024	Facilities - Jan 2024	Limited	Chief Operating Officer	High	R3.2	Frequent stock takes should be undertaken, to ensure any stock discrepancies can be investigated, in accordance with the principles of the Financial Control Procedure: Stores and Stocks.Any discrepancies should be investigated immediately and where discrepancies cannot be resolved this should be raised with senior management. Where minimum and maximum stock levels are in place this should be reviewed to ensure they are still appropriate following the pandemic, alongside the reduction in footfall within the canteen and following pricing updates.	ACCEPTED The following steps will be taken to address the issue:A process for reporting, investigating and escalating discrepancies will be developed and implemented in 'flow chart' form.	29/02/2024	1486.92		0.00		Overdue						31/03/2024

Internal	2024	Facilities - Jan 2024	Limited	Chief Operating Officer	High	R3.3	Frequent stock takes should be undertaken, to ensure any stock discrepancies can be investigated, in accordance with the principles of the Financial Control Procedure: Stores and Stocks.Any discrepancies should be investigated immediately and where discrepancies cannot be resolved this should be raised with senior management. Where minimum and maximum stock levels are in place this should be reviewed to ensure they are still appropriate following the pandemic, alongside the reduction in footfall within the canteen and following pricing updates.	Initiate a review of current minimum and maximum stock levels to ensure that they remain accurate, then either: • Update the required minimum and maximum levels, alongside a process for regular review, or • Use software to determine stock levels/required orders	29/02/2024	1486.92		0.00		Overdue								31/03/2024
Internal	2024	Facilities - Jan 2024	Limited	Chief Operating Officer	Medium	R4.1	Management should review the processes in place for receiving the delivery of stock and implement a consistent approach across each site. For example, a comparison between the delivery and the order sheet. Where the ordering and receipting process happens within different departments, management should ensure all staff are aware of their responsibilities.When stock is signed as accepted and correct, but stock errors continue to be accepted, management should investigate these occurrences and undertake appropriate action.	ACCEPTED. The following steps will be taken to address the issue: 1. Review and update processes for the receiving and delivery of stock. A single process will be developed and implemented across each of the Health Board sites.	29/02/2024	1486.92		0.00		Overdue								31/03/2024
Internal	2024	Facilities - Jan 2024	Limited	Chief Operating Officer	Medium	R4.2	Management should review the processes in place for receiving the delivery of stock and implement a consistent approach across each site. For example, a comparison between the delivery and the order sheet. Where the ordering and receipting process happens within different departments, management should ensure all staff are aware of their responsibilities.When stock is signed as accepted and correct, but stock errors continue to be accepted, management should investigate these occurrences and undertake appropriate action.	2. The responsibilities of each person involved in the stock ordering, receipting, delivery and management process will be reviewed and clearly detailed. All people involved in the new process will be provided training	29/02/2024	1486.92		0.00		Overdue								31/03/2024
Internal	2024	Facilities - Jan 2024	Limited	Chief Operating Officer	Medium	R4.3	Management should review the processes in place for receiving the delivery of stock and implement a consistent approach across each site. For example, a comparison between the delivery and the order sheet. Where the ordering and receipting process happens within different departments, management should ensure all staff are aware of their responsibilities.When stock is signed as accepted and correct, but stock errors continue to be accepted, management should investigate these occurrences and undertake appropriate action.	3. Implement a system to monitor and review errors in the end-to-end process, including escalation and investigation in line with all stock ordering and control issues identified within this report.	29/02/2024	1486.92		0.00		Overdue								31/03/2024
Internal	2024	Facilities - Jan 2024	Limited	Chief Operating Officer	Medium	R5.1	Management should review the security arrangements at each site and if appropriate to do so, add additional security measures where required.	ACCEPTED. The following steps will be taken to address the issue:Undertake a Privacy Impact Assessment in conjunction with Information Governance to assess the viability of CCTV cameras within stock areas	29/02/2024			0.00		Overdue								31/03/2024
Internal	2024	Facilities - Jan	Limited	Chief Operating	Medium	R5.2	Management should review the security arrangements at each site and if	1 Review processes for staff access. To ensure that processes are in place to ensure all goods are secured and accessed in a	29/02/2024	1486.92		0.00		Overdue								31/03/2024

Internal	2024	Facilities - Jan 2024	Limited	Chief Operating Officer	Medium	R5.2	appropriate to do so, add additional security measures where required.	controlled environment.	29/02/2024	1486.92		0.00		Overdue						31/03/2024
Internal	2024	Facilities - Jan 2024	Limited	Chief Operating Officer	Medium	R5.3	Management should review the security arrangements at each site and if appropriate to do so, add additional security measures where required.	2 Ensure stock ordering, management and control processes easily identify stock anomalies and there is a robust process for investigation and escalation	01/03/2024	1486.95		0.00		Overdue						31/03/2024
Internal	2024	Facilities - Jan 2024	Limited	Chief Operating Officer	High	R6.1	Management should review how they measure and monitor waste and ensure a consistent approach across all sites. There should also be consideration of the use of extended functionality within Synbiotix and / or the recording of food waste for management information.	Develop a process, in flow chart form, to effectively monitor food waste	29/02/2024	1486.92		0.00		Overdue						31/03/2024
Internal	2024	Facilities - Jan 2024	Limited	Chief Operating Officer	High	R6.2	Waste levels should be monitored and reported to the monthly Facilities meetings and any anomalies investigated.	Food waste to be presented to and monitored by the Head of Facilities, as part of monthly performance highlight report at Facilities Management Team meetings	31/03/2024	1487.93				Overdue						31/03/2024
Internal	2024	Facilities - Jan 2024	Limited	Chief Operating Officer	Medium	R7.1	Management should investigate the following system improvements and implement if appropriate:Stock Management System • the functionality between Oracle and Synbiotix to create a functional and effective stock management system; and • the designation of preferred stock within Oracle, e.g. a particular brand of bread loaf and adding this to the ordering sheet that is sent to managers for approval, to assist with the selection of the lowest cost item.	explore the feasibility of using the stock control element of the Synbiotix system as it has the ability to record all goods received and track their usageand assess other stock management systems	29/02/2024	1486.92				Overdue						31/03/2024
Internal	2024	Facilities - Jan 2024	Limited	Chief Operating Officer	Medium	R7.2	Management should investigate the following system improvements and implement if appropriate:Stock Management System • the functionality between Oracle and Synbiotix to create a functional and effective stock management system; and • the designation of preferred stock within Oracle, e.g. a particular brand of bread loaf and adding this to the ordering sheet that is sent to managers for approval, to assist with the selection of the lowest cost item.	Ad-hoc audits of all items ordered via oracle on a monthly basis to ensure all sites are adhering to the approved stock items	29/02/2024	1486.92				Overdue						31/03/2024

Internal	2024	Facilities - Jan 2024	Limited	Chief Operating Officer	Medium	R7.4	Management should investigate the following system improvements and implement if appropriate: Bank: • the possibility of using the AllocateMe function within the Bank Staff system to create a better approach to allocating bank shifts to a wider pool of staff; • utilisation of Safe Care or Allocate to monitor when staff start and end their shift; and • the completion of the programme of work to prevent staff from completing all associated steps of approving and paying a bank shift.	Explore the use of safe care or alternative system to monitor staffs start and finish time this is part of the pre-enabling plan for the roll out Health Roster payroll drop down.	29/02/2024	1486.92				Overdue								31/03/2024
Internal	2024	Facilities - Jan 2024	Limited	Chief Operating Officer	Medium	R7.5	Management should investigate the following system improvements and implement if appropriate: Bank: • the possibility of using the AllocateMe function within the Bank Staff system to create a better approach to allocating bank shifts to a wider pool of staff; • utilisation of Safe Care or Allocate to monitor when staff start and end their shift; and • the completion of the programme of work to prevent staff from completing all associated steps of approving and paying a bank shift.	As part of the Health Roster payroll drop down project and pre enabling plan a review of all staff's access levels will be undertaken	29/02/2024	1486.92				Overdue								31/03/2024
Internal	2024	Facilities - Jan 2024	Limited	Chief Operating Officer	Medium	R7.6	Management should investigate the following system improvements and implement if appropriate: Bank: • the possibility of using the AllocateMe function within the Bank Staff system to create a better approach to allocating bank shifts to a wider pool of staff; • utilisation of Safe Care or Allocate to monitor when staff start and end their shift; and • the completion of the programme of work to prevent staff from completing all associated steps of approving and paying a bank shift.	Managers to be responsible and accountable for reviewing and approving Health Rosters in line with Health Board policies. This will also include ensuring templates are accurate.	29/02/2024	1486.92				Overdue								31/03/2024
Internal	2024	Facilities - Jan 2024	Limited	Chief Operating Officer	Medium	R7.7	Management should investigate the following system improvements and implement if appropriate: Bank: • the possibility of using the AllocateMe function within the Bank Staff system to create a better approach to allocating bank shifts to a wider pool of staff; • utilisation of Safe Care or Allocate to monitor when staff start and end their shift; and • the completion of the programme of work to prevent staff from completing all associated steps of approving and paying a bank shift.	All members of the management team to undergo formal Health Roster training with Workforce and Organisational Development	31/01/2024	1485.97				Overdue								31/03/2024
Internal	2024	Facilities - Jan 2024	Limited	Chief Operating Officer	Medium	R8.1	Management should continue to monitor and inform staff of their responsibilities regarding bank shifts. Where individuals regularly do not comply with the Health Board's Resource Bank – Booking Rules this should be escalated and dealt with appropriately.	Continue to monitor Bank Shift Booking Reports and address issues in accordance with Health Board policy	31/03/2024	1487.93				Overdue								31/03/2024
Internal	2024	Facilities - Jan	Limited	Chief Operating	Medium	R8.2	Management should continue to monitor and inform staff of their responsibilities regarding bank shifts. Where individuals regularly do not	Implement a process that ensures All non-compliance reported to Head of Facilities, who will ensure that each occurrence is reviewed by the	29/02/2024	1.02				Overdue								31/03/2024

Internal	2024	2024	Limited	Operating Officer	Medium	R6.2	comply with the Health Board's Resource Bank – Booking Rules this should be escalated and dealt with appropriately.	the responsible manager in line with Health Board Policies, with findings presented back to the Head of Facilities.	29/02/2024	-1.02				Overdue							31/05/2024

Appendix 4 - Revised Timescale Requests following Q4 Updates

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Priority	Recommendation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC Comittee	Final Report Deadline Status	Revised Deadline Status	If closed and not complete please provide justification and ensure evidence is avaliable	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close/complete the recommendation?	Reporting Date
Internal	2017.00	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies and Health Science	High	R1	R1 Registers should be maintained for operational management of medical devices and equipmenton each ward and department, which should record relevant equipment details.The register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed.Each areashould ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record itupon theirregister. Discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded. Going forward, relocation of equipment, disposals, additions etc. should be updated promptly to ensure an accurate record continues.	The Health Board to consider investing in an overarching equipment database register with staff resources to ensure regular updating and management.	31/03/2018	-71.87	30/04/2024			Overdue	Not Yet Due		March 2024: The Health Board is compliant with the parts of the recommendation that, (a) registers should be maintained for operational management of medical devices and equipment on each ward and department, which should record relevant equipment details, (b) that the register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed, (d) discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded, and (e) going forward, relocation of equipment, disposals, additions etc. should be updated promptly to ensure an accurate record continues. The Health Board is currently partially compliant concerning the part of the recommendation that (c) each area should ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record it upon their register. "A centrally managed industry standard pan-organisation medical equipment register (Softpro Medusa) is in place and operational. The database records medical equipment management information on each item of equipment, including the location where each item is deployed. Reports can be produced filtered by ward/ department though the on-line Customer Portal. Ward and departmental managers can access a list of equipment in the register that is allocated to their work area from the centralised register via an on-line Customer Portal. The database is overseen by the Health Board's Medical Electronics and Bio-medical Engineering (EMBE) service. There is a programme of periodic register accuracy reviews and of auditing the review processes. The register captures equipment lifecycle stage events and changes to the departments to which particular equipment is allocated. A rolling review programme applied during EBME's routine actions. This will be automated once the RF tracking system is fully implemented. • There is an identified need to create a user guide for using the Medusa Customer Portal. The EBME Service is compiling this information. • The QPS Risk Management team has an audit of non-medical equipment not already recorded in the database ready to deploy.	January 2024: The technical aspects of attaching RFID tags and entering the related data into the Medusa, the Asset Register and the Paragon RFID databases for all equipment has restricted the people conducting the task to skilled and available EBME and Finance staff. Physically accessing equipment, which by design and necessity is mostly in utilisation on patients, has restricted the tagging operation to points of contact with equipment during EBME's routine equipment management operations, which run over a 12-monthly cycle. EBME have not had the resources to create the Customer Portal instructions and disseminate them. The software development between the 3 systems (Softpro Medusa, Ram Asset 4000 and Paragon RFID) is now operational. The unrelenting service pressures however means that there is still an extensive amount of work to visit every site and tag locations and equipment. This is still an ongoing project and work in progress. Assets are being tagged as and when we see them , however the process to blitz equipment tagging is restricted by the ongoing service pressures. There is also the ongoing restructuring of services/departments throughout our LGH's.	January 2024: The dominant risk factor related to this recommendation is of unbalanced investment in equipment, this is assessed as a having a current risk exposure level of 12 (high). The following mitigation actions are identified: · Work is in progress to assure that within the medical equipment and devices register, lists of medical equipment and devices located in our wards and departments are up-to-date and accurate. · Creation of user guide for the Medusa Customer Portal and provision of supporting training where necessary to aid ward and departmental managers in viewing and printing reports on their allocated equipment. · Completion of the roll-out of the Paragon RFID system will remove the need for regular routine manual verification of equipment that is allocated and deployed to work areas that are not sufficiently resourced to prioritise doing this manually. · Amendment to the Health Board's Medical Equipment and Devices Policy to improve clarity of the responsibilities and of ward and departmental managers on managing their allocated medical equipment and devices, and on delegation of this.	Whilst the aim is to tag all medical Equipment & devices throughout the HB hospitals we are focused on completing one major site. This being the GUH and to date out of 3242 assets listed on our database 1341 devices have been tagged, which represents 41.3% of assets on site at the GUH. In total we have RFID tagged over 4100 medical devices to date across our HB sites. Its difficult to commit to a completion date giving the ongoing service pressures, but this work is a daily ongoing process and when time allows we will undertake a blitz approach to RFID tagging the remaining devices, starting at the GUH.	31/03/2024
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R1	R1 The governance framework for IM&T / digital should be clarified and where control over aspects of IM&T has devolved to departments, there should be a process for these to feed into the relevant Committee to ensure oversight. Underneath the Committee the steering group remit and membership should be defined.	Agreed. The Health Board is establishing a new governance framework. Currently Informatics is reporting to the Audit Committee, the first report is scheduled for 8thApril. A Health Board governance framework is in development for informatics including exec oversight, investment and delivery. The management of the global pandemic has disrupted the planning work by 12 months but this is now re initiated. Recommendations arescheduled to be presented to Exec TeamQ1 , and Board in Q2;	30/06/2021	-32.95	31/03/2023			Overdue	Not Yet Due		March 2024: The Information Governance, Health Records and Cyber Security governance groups are now meeting and the first Information Governance Sub-Committee is being held on the 26/03/2024. The Digital, Data & Technology Sub-Committee terms of reference are completed and will be taken to the Executive Committee on the 11th April pending agenda setting.January 2024: The directorates new governance arrangements have been consulted and agreed internally. The Information Governance structure has been approved by the executive committee which will build on the well-established Governance & Assurance groups where there is strong engagement between the Information Governance team and Divisional leadership.				31/03/2024
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R5	R5 The Health Board should ensure greater links with divisions and the Informatics Directorate. The Informatics Directorate should be involved in the decision making process for all IM&T items.	Accepted. The CDO will present the recommended Target Operating Model to the HB which will include governance over Informatics as a Division and also departmental systems. Part of the framework will include decisions to procure and assurance processes not only for informatics division but informatics services owned outside. Part of adoption will help appraise strategic options in how the HB wishes to take this forward. Part of the SIRO objectives will set out the responsibilities for devolved asset owners and a performance management framework to identify risk and provide oversight. There is likely to be a resource impact in achieving this which will be subject to a business case.	31/03/2021	-35.93	31/07/2024			Overdue	Not Yet Due		Mar 24 - Divisional engagement meeting dates for meetings are being established for Families & Therapies and Unscheduled care division and will be in place in April 24 subject to Divisional staff availability. A communications an engagement plan that covers all the activities of the Health Board will be developed in Q1 2024/25. An annual operational plan has been developed to provide a detail account of the delivery plan for 2024/25 to sit alongside the IMTP Digital Enabler section. Divisional meetings are in place for Clinical & Support Services, Scheduled care, Primary & Community care & Urgent Care. New Digital Service Requests are in place to ensure all new requests are reviewed by the Senior Leadership team on a fortnightly basis. The digital enabler component of the IMTP has been completed A Microsoft Team Planner board is in place to track progress and outcome of requests to Projects or production. Internal Directorate communications are in place using Teams channels including a communications, learning & development and job vacancy segments. The Director of Digital has implemented regular online 'town hall' events for the Directorate. The Directorate has very regular lunch and learn sessions for internal and external speakers"Regular Divisional engagement meetings have been expanded to include Urgent Care leaving Mental Health & Learning Disabilities and Medicine to be implemented before the end of March 2024. Each Division will be provided with a 'Digital Buddy', a member of the Directorate Senior Leadership team who will chair the oversight meetings and will provide Divisions with a single point of contact for raising issues with the Directorate. As one of the key planning enablers the directorate participates actively in the annual planning process working with Planning to understand the needs of the service and align digital activities to those needs. The engagement and communication activities of the directorate will be summarised in a new Engagement & Communication Plan. Work is planned to restructure the directorate to enhance its strategic planning and engagement capability and new digital service request process will be implemented by February 2024 to funnel all requests for new services through the senior leadership team with additional appraisal undertaken of requests by the business analyst team with requestors to ensure requirements are understood, are properly documented, and have sufficient detail to enable prioritisation. The directorate recently had a substantial audit report from Internal Audit for its arrangements for stakeholder				31/03/2024
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R8	R8 An assessment of the changes needed to implement the Digital Strategy should be undertaken, and the benefits of the changes articulated, along with the consequences of no change. The Health Board should develop a single roadmap to help deliver the Digital Strategy.	As part of the review Informatics has accepted the need for P3O Portfolio management. This work is ongoing and with an initial focus to core Informatics Division activity but provides a framework for Health Board oversight and transparency. The portfolio approach will extend subject to Board approval to all information assets in a planned programme of work. This forms part of the recommendations to Execs in Q1 2021.	30/06/2021	-32.95	01/05/2024			Overdue	Not Yet Due		Mar 24 - Divisional engagement meeting dates for meetings are being established for Families & Therapies and Unscheduled car & MH&LD division and will be in place in April 24 subject to Divisional staff availability. January 2024: A new digital service request process will be implemented by February 2024 to funnel all requests for new services through the senior leadership team with additional appraisal undertaken of requests by the business analyst team with requestors to ensure requests are understood, are properly documented, and have sufficient detail to enable prioritisation. A key component of this will be strategic alignment with the core local and national digital strategies. The Digital, Data & Technology sub-committee of the Finance & Performance Committee will provide an additional governance space for assurance of the work of the directorate by its Health Board stakeholders as well as the Executive. Progress has been made on the portfolio register to surface all digital work including new service requests and ICT projects. Resource & capacity modelling being developed along with business change tools to support service readiness for change. Internal audit will shortly be undertaking an audit of our portfolio arrangements in line with best practice. Currently the new Data Strategy is currently under development and associated strategies for ICT and Cyber Security are planned for the first quarter this year. The Health Board has commissioned CGI to undertake consultancy of on the future of the Electronic Health & Care record across the organisation and we would expect a report for this in the summer. These strategies will be brought together as an overarching summary Digital Strategy following these developments. Nov 23: The new digital service request process is nearing completion and will shortly be launched across the Health Board. The Digital governance committee will provide assurance on the digital plan and the updated digital programmes framework ensures benefits management will be ingrained on all projects. Aug 23: Progress being made on the portfolio register to surface all digital work including new service requests and ICT projects. Resource & capacity modelling being developed along with business change tools to support service readiness for change. May 2023 - Benefits audit carried out and substantial assurance awarded. Funding to fully establish the PMO not yet secured however a portfolio view of all digital service requests and trnasofmration programmes has been developed along with a prioritisation and optimisation framework. DDOB has been stood down temporarily so prioritisation is done on an ad hoc basis with members of the exec team. Mar 23: Funding required for Head of PMO however, digital Portfolio manager recruitment underway in Programmes and benefits audit completed with substantial assurance. January 2023 - Awaiting funding for Head of PMO. Benefits management audit underway in programmes. September 2022 This is part of the TOE paper submission Oct 22				31/03/2024

Internal	2021.00	Gifts, Hospitality and Declarations of Interest	Reasonable	Director of Corporate Governance	Medium	R1	R1 The Health Board should add an additional section to the declaration of interests form detailing any additional action required to mitigate risk. These measures should be implementedand monitoredby the individual's line manager.b.The Policy and accompanying processes should be updated to support the changes required to mitigate the risk.	a.As identified, whilst there is adherence to the policy, the recommendation provides an opportunity to improve the mechanismswithin departments. To facilitate this the Health Boards ESR will be reviewed to determine how declarations can be digitally captured toenable improved conflictmonitoring and management.Where ESR may not be used (e.g. by Independent Members) then the manual form will be updated to reflect the recommended improvements. b.The policy and process documents will be updated to reflect the amendments.	31/10/2021	-28.92	31/05/2024			Overdue	Not Yet Due		March 2024: A revised Standards for Business Conduct Policy will be submitted to the Board for approval in May 2024. January 2024: Assurance Report Completed. Arrangements for the declaring of interests, gifts and hospitality Included as a governance priority within the IMTP 2022-25 August 2023: Due to gaps within the corporate governance team this work has been delatyed. Recruitment has recently taken place with posts expected to be filled by November 2023. This work should therefore be completed in Q4, 2023/24				31/03/2024
Internal	2021.00	Gifts, Hospitality and Declarations of Interest	Reasonable	Director of Corporate Governance	Medium	R2	R2 The procedures for receiving and processing declarations made should be formalised and include:i.the use of a shared mailbox for all declarations;ii.details of the process for receiving and processing declarationsand the associatedtimescales;iii.details of due diligence to be undertaken on completed declarations;iv.timeframes for reminders to be issued in the event where previous declarations have been submitted; andv.details of any completeness checks to be undertaken to determine if there are missingdeclarations.	To facilitate all recommendationsthe Health Boards ESR will be reviewed to determine how declarations can be digitally captured and enabled toimprove receipt and management. This will facilitate improved recording across the organisation, allow automated reminders, and provide reports to Divisional managers for completion and adherence checks and missing declarations.In addition, where ESR may not be used (e.g. by Independent Members) then the manual form will be updated to reflect the recommended improvements.	31/10/2021	-28.92	31/05/2024			Overdue	Not Yet Due		March 2024: A revised method for the reciept and management of DoIs is incuded in the revised Standards for Business Conduct Policy. January 2024: Assurance Report Completed. Arrangements for the declaring of interests, gifts and hospitality Included as a governance priority within the IMTP 2022-25 August 2023: Due to gaps within the corporate governance team this work has been delatyed. Recruitment has recently taken place with posts expected to be filled by November 2023. This work should therefore be completed in Q4, 2023/24				31/03/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R1	R1 Clarity should be sought over the roles and responsibilities of each party and a governance process established within Radiology that ensures the easy flow of work requests across team boundaries.	We have had a recent upgrade and the boundaries were clearer. The SLA sits with I.T and Radiology are the application owner. ABUHB Radiology internally request on service point if the department knows the server team need to undertake work. We will continue to do this.	01/03/2022	-24.95	31/05/2024			Overdue	Not Yet Due		March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24. January 2024: Please refer to completed assurance report.			Targetted training is provided to teams in the meantime.		31/03/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R5.1	R5.1 The Board should introduce a completeness check to ensure that all requests received have been entered into WRIS.	Staff have SOP's and checks when putting forms on however human errors do occur without fully electronic requesting.	30/06/2022	-20.98	31/05/2024			Overdue	Not Yet Due		March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24. January 2024: Please refer to completed assurance report.			Targetted training is provided to teams in the meantime.		31/03/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating	Medium	R4	R4 The Health Board should seek clarity over what maintenance tasks are expected and establish a process to ensure that these are	There is a backup regimen in place, and DHCW has been notified of how this works.The point will be raised and the next WRIS	31/03/2022	-23.87	31/05/2024			Overdue	Not Yet Due		March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24. January 2024: Please refer to completed assurance report.		RadIS will not support this with the alerts and notifications	The database has been backed up by the server team		31/03/2024

Internal	2021.12	Controls (WRIS)	le	Operating Officer	m	R4	tasks are expected and establish a process to ensure that these are completed.	SMB, and a request made for clarity over the expected database maintenance tasks and the frequency of these.	31/03/2022	-23.97	31/05/2024			Overdue	Not Yet Due	May 24. January 2024: Please refer to completed assurance report. A database that the alerts and notifications is on is not supported by RadIS.	query on the server still.	The database has been backed up by the server team		31/03/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R5	R5 The Board should investigate an electronic solution to uploading requests into WRIS.	Radiology have requested CWS to work with WCP for fully electronic requesting.	31/03/2022	-23.97	31/05/2024			Overdue	Not Yet Due	March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24. January 2024: Please refer to completed assurance report. Aug 2023: The UAT has been passed and this is currently being looked at by informatics	Aug 2023: Required scoping, testing and development and planned for software development Needs to be agreed locally and product developed to suit ABUHB			31/03/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R6	R6 Password controls should be improved with an increased minimum length and the Board should reduce the default maximum attempts available.	Since this audit,this has now been altered and note it wasonlyone user with this many attempts all Administrators now have 5 attempts.	01/03/2022	-24.95	31/05/2024			Overdue	Not Yet Due	March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24. January 2024: Please refer to completed assurance report. Nov 2023: currently trialling in primary care which has been succesful and is with software developments and informatics bussiness analysist to scope out as this is the selected solution from RISP.	Would need to staple in WCP ETR into CWS once the project has been scoped and timlined.	We have got checks for clinicians with similar names for obvious booking errors.		31/03/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R7	R7 The success of the use of the leavers list should be monitored to ensure that it works as anticipated and that all leaver accounts are removed on a timely basis.	We monitor this as much possible in Radiology. We have recently started receiving consultant leaver'slists from the Health Board and action these also.The success of the process will be tracked and evaluated to ensure it is working.	30/04/2022	-22.98	31/05/2024			Overdue	Not Yet Due	March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24. January 2024: Please refer to completed assurance report. Aug 2023: Any leavers we will make inactive unless access is required for global imaging within PACS or cross boundry electronic requesting if they are still working within the Welsh NHS. We are still dependant on this list being provided.				31/03/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R8	R8 The Health Boardshould request that this logging function be developed and should consider feeding WRIS events into the SIEM.	The health board have raised this at DHCW CAB along with other health boards. This is with DHCW to develop it is not in any Live RadIS version currently.	31/03/2022	-23.97	31/05/2024			Overdue	Not Yet Due	March 2024: Position remains the same further progress expected May 24. Currently with DHCW to develop,	Time and resource in RadIS. As well as pending RISP program may not help development.			31/03/2024

Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R9	R9 A formal disaster recovery plan for WRIS should be developed.	The Disaster recovery plan is to fail over to a mirrored system however, since the upgrade this needs to be re-visited and formally set out. ABUHB have a VMware environment where this is hosted.The Radiology departments have disaster recovery by using emergency packs in each department and a policy that explains how to use these emergency packs in a Radis downtime scenario.	30/04/2022	-22.98	31/05/2024			Overdue	Not Yet Due		March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24. January 2024: Please refer to completed assurance report. Aug 2023: The BC plans in radiology are quite extensive and well practiced	Aug 2023: Time and resource in RadIS. As well as pending RISP program may not help development.			31/03/2024
Internal	2021.20	Medicines Managment	Reasonable	Medical Director	Medium	R2	R2.1 Management should review the Policy for the Management of Controlled Drugs and update where required.	The CD Policy is due for review during 2022/23. As in previous reviews a working group with representatives from Pharmacy and nursing will be set up to update the policy. A number of sections and standard operating procedures will be updated to make the policy more relevant and practical. This will support compliance with the policy. Controlled drug keys being held on their own may have been best practice. However, this may not be convenient on the wards. This could be removed in the updated version.The use of red pen on the wards is to make stock checks morevisible. The practicality of this will be reviewed.Keeping patients own CDs on a separate shelf may not always be possible. However, they should be clearly differentiated from ward stock.The policy will also include a description of the audit framework that will provide assurance the policy is being followed.	31/03/2023	-12.00	31/05/2024			Overdue	Not Yet Due		Update March 2024: Policy extended with review date 31st May 2024. Revised policy due to be provided to Clinical Policy & Standards Group 9th May 2024. Update Aug 2023: The review date of the current policy is November 2023. Progress to review and update it was delayed to ensure compliance with the Welsh Government notification to ensure HB compliance with new Home Office licensing requirements for the Management of Controlled Drugs (this was issued late February 2023). Priority was given to the clinical areas where these licenses are required and to support the application process (ABSDAS services and community dental clinics). The new Home Office licensing arrangements will be included in the Management of Controlled Drugs Policy. The requirements within the Controlled Drugs Policy review identified several aspects that needed to be updated to reflect the changes in working practices. The revised operational procedures are being implemented prior to introduction of the new policy and are expected to be completed by the end August 2023. A revised Management of Controlled Drugs Policy has been drafted and is being reviewed across the Divisions and will provided to the Clinical Standards and Policy Group in November 2023 for approval.	Delay due to HMRC licencing requirements		ABUHB_Clinical_0552 Management of Controlled Drugs Policy_Issue 6	31/03/2024
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Low	R1	R1 For future iterations of the CAF there should be greater involvement of the system owners in the review of the responses.	ABUHB will ensure that in future iterations of the CAF there is greater involvement of System Owners	31/12/2022	-14.95	31/05/2024			Overdue	Not Yet Due		March 2024: Cyber continues to attend GAG (Governance and Assurance Groups) meetings when scheduled with divisions to highlight the need of Information Asset Owners (IAO) and Senior Information Asset Owners (SIAO). CSAG (Cyber Security Assurance Group) meeting has been postponed due to circumstances within the team, this will be rearranged when applicable. Attendees have been identified and agreed with the SIRO. Terms of Reference will be covered in the first scheduled meeting, January 2024: The Cyber Resilient Unit assessment is now scheduled for 22/01/2024. There was a pre assessment meeting arranged with the CRU before the new year to discuss scope and this included Information Asset Owners.There is strong engagement through our divisional assurance arrangements where regular meetings are held between the divisions and our cyber security team. This will be further strengthened with the Cyber Security Assurance Group which will be meeting for the first time this quarter. Nov 23: CRU assessment now scheduled for 22/01/2024. There will be a pre assessment meeting arranged by CRU in Nov/Dev to discuss scope and Digital will ensure this includes Information Asset Owners. Aug-23: CRU have provisionally provided a date for the next NIS CAF assessment process Oct 2023. As part of the engagement CRU have suggested a hybrid approach with onsite visits and interviews with systems owners. This is being piloted currently but is a process change from the previous assessment process undertaken in 2021				31/03/2024
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Medium	R2	R2 Management should ensure that records of discussions and information provided to and from the CRU are captured for future annual self-assessments.	Management will ensure that during any future self-assessments records of discussions and informationsupplied to the CRU will be captured and available for internal or external review.	31/12/2022	-14.95	31/05/2024			Overdue	Not Yet Due		March 2024: As part of the NIS CAF, CRU have supplied Cyber with a "Findings Update" Excel documentation, which allows Cyber to provide monthly updates against the outcome recommendations for the Principle(s). Currently, Cyber's responsibility is to gather updates for CRU from Remedial Action Owners until CSAG (Cyber Security Assurance Group) meetings are held; however, CRU require monthly updates and CSAG will be on a quarterly basis. We are reviewing the project management arrangements to ensure the reporting requirements can be met. January 2024: In our assessment with the Cyber Resilience Unit in January we are discussing the documentation requirements and how we can ensure this audit recommendation can be satisfied going forward. Nov 23: CRU will outline what documentation/evidence they expect to be provided at the pre assessemnt scoping meeting prior to our January assessment. This is due to be held Nov/Dec 2023 Aug-23:CRU are piloting process changes to their approach from their initial NIS assessment undertaken in 2021, Future NIS CAF assessments will include evidence gathering ,recording and reporting as part of the new format.				31/03/2024
Internal	2021.22	NIS Directive	Reasonable	Director of	Medium	R4	R4 The costs associated with the improvement actions should be assessed and reported to a relevant committee to enable	The NIS Improvement Plan will be submitted through the relevant governance committee for senior Management review and sign off. Prioritisation of remedial actions and related costs will be assessed through ABUHB formal risk governance structureand	30/09/2022	-17.07	31/05/2024			Overdue	Not Yet Due		March 2024: Due to unforeseen circumstances, Cyber has postponed the first meeting of the Cyber Security Assurance Group (CSAG) and is yet to set a rearranged date and time. Attendees have been agreed by the Cyber Security Manager and the SIRO and a Terms of Reference (TOR) paper has been created in readiness of this meeting. January 2024: New Cyber Security Assurance Group will be meeting in January and will provide assurance through the Information Governance Sub-Committee including progress against the NIS action plan which has now been developed. Any associated costs will be captured as part of the Digital IMTP planning process and will form the basis of associated capital plans and potential bids to Welsh Government. Nov 23: New Cyber Security Assurance Group will be meeting in January and will provide assurance through the Information				31/03/2024

Internal	2021.22	(Cyber Security)	le	Digital	m	R4	awareness of the full picture and prioritisation of actions and funding.	relevant committees. Note ABUHB are currently implementing the recommendations of the Templar consultancy report which will create the Office of the SIRO and create a new governance frameworkto support Risk Management within the Health Board.	30/09/2022	-17.97	31/05/2024			Overdue	Not Yet Due	Governance Sub-Committee including progress against the NIS action plan which has now been developed. Any associated costs will be captured as part of the Digital IMTP planning process. AUG 2023: Awaiting next HBOTS meeting. May 23: work to commence shortly under SIRO Mar 23: Part of work programme that will be commencing from May under Rani Jan 23: Office of he SIRO has been established, implementation of supporting governance and structures are in progress allowing costs to be fully assessed and actions prioritised. Aug 22: The creation of the TOM and creation of the HBOTS is ongoing This will provide the risk management framework to allow costs associated to improvements to be managed and prioritised."				31/03/2024
Internal	2021.22	NIS Directive (Cyber Security)	Reasonab le	Director of Digital	Mediu m	R5	R5 A formal reporting route for cyber security should be established to ensure that senior staff are aware of the position relating to cyber security and the risk description should be reviewed, with inclusion of the potential financial penalties relating to noncompliancewith NIS.	ABUHB are adopting recommendations of the Templar Report that will establish a formal risk governance and committee structure within the Health Board which will support Cyber Security Risk Reporting.5.2As part of the improvements suggested by Templar a new Cyber Risk Register will be developed. As part of development process account will be taken to include the financial penalties associated with noncompliance to NIS regulatory requirements into the assessment methodology and reporting.	30/09/2022	-17.97	31/05/2024			Overdue	Not Yet Due	March 2024: The first Information Governance Sub-Committee meeting has been postponed until March 26th; however, the Cyber Security Assurance Group (CSAG) are yet to have their first initial meeting. January 2024: The new Information Governance Sub-Committee will have its first meeting in February and will have a Cyber Security Assurance Group reporting too it which will have its first meeting in January 2024.Regularly report of cyber incidents, risk, awareness and training will be provided to the Finance and Performance Committee through reporting from the Information Governance Sub-Committee. Nov 23: New Information Governance Sub-Committee will have its first meeting in February and will have a Cyber Security Assurance Group reporting too it which will have its first meeting in January 2024 Aug 2023: Awaiting next HBOTS meeting. May 23: work to commence shortly under SIRO Mar 23: Part of work programme that will be commencing from May under Rani Jan 23: Regular cyber reporting is in place, currently this runs through Digital Delivery Oversight Board and to execs. This will change to HBOTS/SIRO once fully established Sept 22. The reporting route is being established following the appointment of the new SIRO. Aug 22: Work is ongoing to implement the TOM and supporting Risk management framework, A governance and Assurance Committee has been established this will report IG and Cyber risks identified at the GAGS through to the HBOTS . This will be supported by a corporate risk management methodology. The assessment methodology and risk scoring will capture the costs of non compliance to NIS and subsequent financial penalties that could be imposed."				31/03/2024
Internal	2021.24	Flow Centre	Reasonab le	Chief Operating Officer	Low	R3	R3 The Flow Centre Team should develop key performance indicators to help improve the delivery of the service, manage key risks and to help develop staff.	With recent changes in clinical and operational leadership of the Flow Centre a focus will be on creating these key performance indicators (KPI) and stabilising the services as we recover from the impact of COVID. Create operational KPI for Pre-Hospital Screening. Create clinical KPI for Intersite transfer service. Review the clinical and operational model of the Flow Centre	30/09/2022	-17.97	31/05/2024			Overdue	Not Yet Due	March 2024: Further progress expected May 2024 following "Band 7 team embedded, new phone system reporting, the new patient record system up and running and staff recruitment" Mar 23•Some KPIs have been created, reviewed each week at SLR and will form the basis of the Flow Centre Review currently taking place	Mar 23 Review being undertaken currently			31/03/2024
Internal	2021.24	Flow Centre	Reasonab le	Chief Operating Officer	Mediu m	R4	R4. We recommend that the Flow Centre Team review and update the business continuity plan, where required.	The business continuity plan is being reviewed and updated currently.	30/06/2022	-20.98	31/05/2024			Overdue	Not Yet Due	March 2024: Further progress expected May 2024 following "Band 7 team embedded, new phone system reporting, the new patient record system up and running and staff recruitment" Aug 2023: In light of recent BC events we will review update and test this accordingly Mar 23 •The BCP has been created/updated and is due for a further review in light of recent IT risks and the joining of the Urgent Care Division	Mar 23 recent Divsional changes have meant that the BCP now requires further refinement however, orginal recommendation was implemented.			31/03/2024
Internal	2021.24	Flow Centre	Reasonab le	Chief Operating Officer	Low	R4.1	R4.1 We recommend that the Flow Centre Team periodically test their business continuity plan and update it with learnings from the exercise(s).	A planned test of the business continuity plan will be initiated by the target date. An unplanned test of the business continuity plan will be initiated by the target date	30/10/2022	-16.98	31/05/2024			Overdue	Not Yet Due	March 2024: Further progress expected May 2024 following "Band 7 team embedded, new phone system reporting, the new patient record system up and running and staff recruitment" Aug 2023: In light of recent BC events we will review update and test this accordingly Mar 23 •This is on hold until we return to our call centre.				31/03/2024

Internal	2022.05	Digital Benefits Realisation	Substantial	Director of Digital	Medium	R1	R1 - The Health Board should finalise the "front of house" process and enable a process for a holistic prioritisation of programmes.	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 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.	01/06/2023	-9.97	31/05/2024			Overdue	Not Yet Due		March 2024: The new digital service request has been drafted and will be completed by end of March 2024 for dissemination and implementation and will be presented to Exec Board in April 2024. Jan 24: A new digital service request process will be implemented by March 2024 to funnel all new service requests using a request form in our Seren ICT portal through the DDaT senior leadership team with additional appraisal of requests undertaken by the business analysis team with requestors to ensure requests are understood, properly documented and managed and have sufficient detail to enable prioritisation and scaling to enable prioritisation and progression in alignment with Health Board priorities. Nov 23: The new digital service request process is nearing completion and will be launched shortly across the Health Board. The digital governance committee will provide assurance on the digital plan and the updated digital programmes framework ensures benefits management will be ingrained in all projects. Aug-23: The Director of Digital has completed the review of the Front of House process and this is being finalised prior to approval by the Executive Committee in October which will include strengthening the financial and governance controls				31/03/2024
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Low	R2	R2 The Health Board should not embed documents / files / forms etc. within a policy document hosted on the intranet. If a form is applicable, it should form part of the appendices or be referenced separately.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), the Quality Assurance process will be strengthened and implemented.	29/09/2023	-6.03	31/05/2024			Overdue	Not Yet Due		March 2024: This is being actioned for newly approved policies and work will be undertaken to address this retrospectively as part of the review of the policy database. Work is underway to review the overarching policy framework and supporting guidance, this will include the requirements around embedded documents. November 2023: This is being actioned for newly approved policies and work will be undertaken to address this retrospectively as part of the review of the policy database. Work is underway to review the overarching policy framework and supporting guidance, this will include the requirements around embedded documents.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues	November 2023: Any new policies are checked for embedded documents prior to publication		31/03/2024
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Low	R3	R3 The Health Board should consider the relevant Health and Care Standards when reviewing / updating a policy or other relevant documentation. An acknowledgement of this process should be included, together with the titles of the relevant Standards included.	The introduction of the Duty of Quality, under the Health and Social Care (Quality and Engagement) (Wales) Act 2020, will see the Health and Care Standards (April 2015) removed and replaced with Quality Standards 2023. As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), the introduction of the Quality Standards 2023 will be considered, and policy templates updated as they are reviewed/developed.	29/09/2023	-6.03	31/05/2024			Overdue	Not Yet Due		March 2024: This will be included as part of the revised framework November 2023: This will be included as part of the revised framework	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			31/03/2024
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Medium	R4	R4 The Health Board, alongside recommendation 3.1 should consider automating the submission of a policy from the responsible owner, to ensure that a consistent submission format is adhered to.	An integrated electronic policy management system will be explored, learning from other health bodies, with an implementation plan developed to support the most appropriate system.	29/09/2023	-6.03	31/05/2024			Overdue	Not Yet Due		March 2024: All policies are now managed via sharepoint, with an automated flagging and reminder system in place at 6 months prior to review, 3 months and when policy is overdue. A review of templates and submission process will be included in the revised policy framework being developed. November 2023: All policies are now managed via sharepoint, with an automated flagging and reminder system in place at 6 months prior to review, 3 months and when policy is overdue. A review of templates and submission process will be included in the revised policy framework being developed.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			31/03/2024
Internal	2022.11	Policies	Limited	Director of Corporate Governance	High	R5	R5 The Health Board should consider fully automating the reminder / management process of all relevant policies / documentation hosted on the intranet. This could be achieved through the use of Power Automate, Lists and other apps within Office 365. An automated work flow would undertake a periodic (e.g. weekly) check of all policies listed on the central spreadsheet that are overdue for review and issue automatic	An integrated electronic policy management system will be explored, learning from other health bodies, with an	29/09/2023	-6.03	31/05/2024			Overdue	Not Yet Due		March 2024: Partially complete. Automated emails sent to policy manager advising of those policies due for review within 6 months/3 months and overdue in order to initiate reminders. Reporting to Committees to be established as paert of the review of the policies framework and implementation of a scheme of delegation for policy approval. November	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure.			31/03/2024

Internal	2022.11	Policies	Limited	Corporate Governance	High	R5	central spreadsheet that are overdue for review and issue automatic emails to the document owners. Following this, escalation to the respective Executive Director can also be completed automatically if documentation is still not updated in a timely manner. This would also allow for real-time reporting of documents that are overdue for review, to provide assurance to the respective Committees.	implementation plan developed to support the most appropriate system.	29/09/2023	-6.03	31/05/2024			Overdue	Not Yet Due	2023: Partially complete. Automated emails sent to policy manager advising of those policies due for review within 6 months/3 months and overdue in order to initiate reminders. Reporting to Committees to be established as paert of the review of the policies framework and implementation of a scheme of delegation for policy approval.	team. Addressed via corporate governance re structure. Posts now in place and work continues			31/03/2024
Internal	2022.11	Policies	Limited	Director of Corporate Governance	High	R6	R6 Once the Health Board has completed a review of all existing policy documentation, document reviews should be undertaken prior to the dates stated for review. Where exceptions remain, there should be an escalation process introduced to include the responsible Executive Director and potentially the Chief Executive Officer / Audit, Risk and Assurance Committee.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), the review and escalation process will be strengthened and implemented.	29/09/2023	-6.03	31/05/2024			Overdue	Not Yet Due	March 2024: Automated email notifications in place to improve reminders to policy owners when policies are due for review. Escalation process to be clarified in revised policies framework. November 2023: Automated email notifications in place to improve reminders to policy owners when policies are due for review. Escalation process to be clarified in revised policies framework.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			31/03/2024
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Medium	R7	R7 The Health Board should complete a data accuracy review exercise of the policies and documents, alongside recommendation 2.1. Where data discrepancies exist these should be updated immediately to the correct value.	A review of the central base (881 documents) is underway, working with divisions, to review the status of each document and respective owners.	29/09/2023	-6.03	31/05/2024			Overdue	Not Yet Due	March 2024: Review of database undertaken and checked against current policies. Executive leads have been issued with a schedule of policies assigned to them for review and confirmation of status. November 2023: Review of database undertaken and checked against current policies. Executive leads have been issued with a schedule of policies assigned to them for review and confirmation of status.	November 2023: capacity to review policies given current operational and financial pressures.			31/03/2024
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Medium	R1	R1 The Health Board should review the types of policy documents retained and hosted, to determine if each of them should adhere to the Policy, for example, departmental standard operating procedures to be managed entirely within the respective division. Alongside this review, the document owner should be determined to ensure the responsibility remains with the most appropriate individual.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), clarity will be provided on which WCDs are to be held centrally and which are to be managed within services and teams. A review of the central base (881 documents) is underway, working with divisions, to review the status of each document and respective owners.	45,016.00	-12.00	31/05/2024			Overdue	Not Yet Due	March 2024: Policy Framework currently under review. This will provide clear definitions of policies, procedures, guidelines and what constitutes an organisational policy. Scheme of delegation to be developed to support organisational policies which will be monitored by corporate governance, and departmental policies which will be led by individual departments (but held within the overall database) November 2023: Policy Framework currently under review. This will provide clear definitions of policies, procedures, guidelines and what constitutes an organisational policy. Scheme of delegation to be developed to support organisational policies which will be monitored by corporate governance, and departmental policies which will be led by individual departments (but held within the overall database)	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			31/03/2024
Internal	2022.12	Records Management	Limited	Director of Digital	Medium	R13	R13 All records should be formally tracked to ensure that they are retrievable when they are needed.	a.) The Business case for DHR phase 3 is in development, this will include the scanning of paper records to be available to view in CWS/cCube Portal negating the need for tracking. b.) Future phases for community, District Nursing, children's services and therapies are being planned and expedited and tracking will be implemented.	31/12/2023	-2.98	30/06/2024			Overdue	Not Yet Due	Mar 24 - Phase 3 Mental Health, Community, District Nursing, Childrens Services Business case with Director of Digital for review.				31/03/2024

Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Medium	R2	Benefits realisation should be established as part of the go-live for automated processes, with the relevant department being required to monitor and confirm the benefits.	Benefits realisation is identified and confirmed by relevant departments and this will now be formally monitored and confirmed by the governance board. This is in part contingent on a successful business case.	28/06/2023	-9.08	30/06/2024			Overdue	Not Yet Due		Mar 24 - an RPA architect has been recruited and will be in post in April 2024. The interim product specialist is implementing a beneits register. This work will be ongoing during April and May 2024. Nov 23: Dependent on recruitment of of resources for RPA Aug-23: Service request forms and opportunity assessment form redesigned to provide better profiling of benefits. Process agreed by RPA Board for requesting service Finance BPA assurance of benefits before automations are agreed				31/03/2024
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Medium	R3	Consideration should be given to establishing a benefits sharing framework for cash releasing savings that would enable the RPA function to be self-sufficient.	This is not a unique issue to RPA but reflects the need for benefits realisation to include (when corroborated and confirmed) sharing of benefits including financial where this is the case. In order to mitigate the risk of priority based on ability to pay the process needs to be owned and curated at health board level rather than between departments. This recommendation will be considered in the case.	31/03/2023	-12.00	30/06/2024			Overdue	Not Yet Due		Mar 24 - a benefits management framework is being implemented in RPA. Benefits are captured duing the RPA opportunity assessment process (see above line 15). Nov 23: Dependent on recruitment of of resources for RPA Aug-23: Service request forms and opportunity assessment form redesigned to provide better profiling of benefits. Process agreed by RPA Board for requesting service Finance BPA assurance of benefits before automations are agreed				31/03/2024
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Medium	R4	The Health Board should seek to complete recruitment and staff the RPA team accordingly.	A revised business case is expected to be submitted to Executive colleagues in Q4.	01/03/2023	-12.98	30/06/2024			Overdue	Not Yet Due		Mar 24 - an RPA architect has been recruited and will be in post in April 2024. The permanent RPA product specialist post is being interviewed in April 2024 Nov 23: Recruitment underway but experiencing delays in attracting the right level of candidates. Aug-23: RPA escalation SBAR presented to Exec Board in March 2023. 2 posts agreed.				31/03/2024
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Medium	R7	The awareness of RPA and the change management process should be strengthened as RPA moves into an operational service. All services should be made aware of the requirement to notify Informatics of changes to any system that may interact with the robots.	Part of the transitional arrangements to operational services will be refined and robust service management arrangements. This is subject to a successful business case.	01/03/2023	-12.98	30/06/2024			Overdue	Not Yet Due		Mar 24 - an RPA architect has been recruited and will be in post in April 2024. The permanent RPA product specialist post is being intrviewed in April 2024. Handover needs to be completed from the RPA contractor and the product specilist recruited to enable the work to be undertaken to complete this recommendation Nov 23: Dependent on recruitment of of resources for RPA Aug-23: Transition to BASU will be undertaken when posts are appointed q3 2023				31/03/2024
Internal	2022.15	IT Strategy	Reasonable	Director of	Medium	R3	The role of the CCIO and CNIO should be fully defined	2.1a The CCIO currently has an AMD role profile. There has been discussions for some time in terms of role design and accountability with the CCIO MD CEO and CDO. A model role	01/06/2023	9.97	30/09/2024			Overdue	Not Yet Due		March '24 - no confimation of resourcing to support clinical engagement. Position not changed. CNIO position to be reviewed with Digital / Nursing directors with the retirement of current CNIO in July '25 Jan 24: Future arrangements and resourcing to support the clinical engagement across the Health Board will be				31/03/2024

Internal	2022.15	IT Strategy	Reasonable	Director of Digital	Medium	R2	The role of the CCIO and CNIO should be fully defined.	profile based on the Faculty of Clinical Informatics example has been agreed and is now being localised. The CNIO has a full role profile and agreed Job description	01/06/2023	-9.97	30/09/2024			Overdue	Not Yet Due	presented to the Executive Committee in early March. This will create a formal structure of CNIO and CCIO's and a relaunch of the Clinical Council. Nov 23: CNIO role established. Work continuing on formalising the CCIO role. Aug-23: CNIO aspects of this have been met				31/03/2024
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	Medium	R3	Leads within divisions should be established to work with the CCIO / CNIO	The principle of Divisional Leads is accepted by the health board. The proposition now needs to be explored and defined in a proposal by the CCIO and CNIO to the Digital Delivery Oversight Board.	01/06/2023	-9.97	30/09/2024			Overdue	Not Yet Due	March'24 - Dependency on agreement of clinial enagement model. This can not be undertaken until that is agreed. HAR group review has identified a number of skateholders who would like to join the council Nov 23: Council not met for several meetings due to capacity issues and will need to be considered due to winter pressures so ToR will be looked at when we meet again Aug-23: Clinical Informatics Council in place and meeting scheduled every 6 weeks, however service pressures have resulted in over half the meetings this year cancelled. More formal job planning needed to release resources to attend	Lack of job profiling to support time to release clinical staff to attend			31/03/2024
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	Low	R5	The skills development work should be formalised into a skills development plan	Agreed. The skills development plan is under development and apprenticeships are actively being explored with the support of Organisational Development colleagues. Informatics are now engaging with other Health Boards who report having commenced apprenticeship schemes	01/12/2023	-3.97	30/09/2024			Overdue	Not Yet Due	March 2024: Application Process will close April 24 . We will receive applications for review and the standard interview process will start for an appointment September 24 "Jan-24: For Digital Specialist Procurement we have identified utilising Network 75, this combines a work placement and part time study as a route to a degree , the ethos of this scheme is for the directorate to grow their own talent for the future. •**A**nalysis of current skills matched to Job Role has been largely completed and gap analysis is being undertaken. •**P**re-requisite certification at Prince II foundation and ITIL v4 foundation desirable against all job roles. •**T**raining Agreement has been implemented and is in use within the directorate but this needs consistency across all departments. •**B**udget restrictions have caused the removal of ring fenced training budget however many staff are taking advantage of non cost training (PLA etc) and being provided protected time for CPD. •**D**evelopment of Learning & Develop Hub is making excellent progress •**N**eed to agree on a skills management platform to implement "				31/03/2024
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	Medium	R4	Work should be undertaken to embed the Clinical Informatics Council and encourage participation therein	Agreed. The CCIO and CNIO will revisit the membership and Terms of Reference for the Clinical Informatics Council which will be included as part of ??	01/06/2023	-9.97	30/09/2024			Overdue	Not Yet Due	March'24 - Dependency on agreement of clinial enagement model. This can not be undertaken until that is agreed Nov 23: Council not met for several meetings due to capacity issues and will need to be considered due to winter pressures so ToR will be looked at when we meet again				31/03/2024
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	Medium	R4	Management should obtain signed lease agreements with relevant parties at the earliest opportunity	Agreed. The provision of signed lease is being actively addressed so that they are in place well before the planned occupation of the building.	01/06/2023	-9.97	30/06/2024			Overdue	Not Yet Due	March 2024: Tredegar Medical Practice (TMP) have recently has become an Independent Practice. Legal & Risk are in connection with TMP solicitors to sign off the Lease. Glan-Y-Afon (GYA), have changed solicitors, Legal & Risk are corresponding with GYA solicitors. GYA had queries which have been responded to. Jan 2024: Still being progressed by Shared Services Aug 2023: NHS Shared Services continue to progess the leases for GMS, Dental and Pharmacy accommodation	None	N/A	Aug 2023: Agreed leases	31/03/2024

Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Low	R2	Consideration should be given to digitalise the "this is me" document and use it as a dementia passport document. Also, make it as a live document which could be further used for home care and nursing home settings	This is me is not a mandatory/Once for Wales NHS tool. There are numerous documents/versions of information that would identify a person needs etc. We shall discuss this and other documents at the next Dementia Board and suggest that Workstream 2a and Workstream 3 leads on this recommendation and determine the feasibility of adding this document to the newly developed patient information portal.	01/06/2023	-9.97	30/09/2024			Overdue	Not Yet Due		March 2024: The challenge of raising awareness of the benefits of this biographical tool is part of an ongoing programme of improvements through the Meaningful Activities and engagement training delivered monthly from the patient Experience and Involvement team. The national Improvement Cymru team are facilitating an All Wales Biographical tool discussion and implementation group which will help support this message of this tool. Dates unconfirmed as being led by Improvement Cymru. Review September 2024 Nov 2023: Review of the outcomes from the National Audit of Dementia there is a recommendation for a relaunch of information to raise awareness of the diagnostic Code for Dementia on Clinical Workstation (136). The information will be added to the Internal Pulse web pages and shared through ABUHB e mail communication network.			Michelle to confirm	31/03/2024
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Medium	R3	It should be clearly defined and communicated in what circumstance alerts should be used. In addition, staff should be trained on how to add alerts to the system	We will review the training and electronic filing requirements for 'alerts' and ensure that clear messages are communicated to the relevant staff	01/07/2023	-8.98	01/10/2024			Overdue	Not Yet Due		March 2024: Applying an Alert to WCCIS was not achievable. The system is not HB wide and time limited. As part of the National Audit of Dementia and the Dementia Hospital Steering group and alert has been introduced for the CWS (Clinical Work Station). An alert will be displayed on patient record using an input code of 136. A briefing document, flow chart and review process is in place to monitor the impact of this as a measurement of people with dementia on our inpatient wards and attending out patient departments. The GP read codes for dementia diagnosis have been reviewed by WG and a reminder document disseminated across MAS and NCN. Primary care divisions.				31/03/2024
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Low	R3	Training should be provided to ensure a consistent approach for the electronic and paper records completion	We will review the training components and update where required, to ensure a consistent approach is adopted	01/07/2023	-8.98	31/07/2024			Overdue	Not Yet Due		March 2024: No further action via WCCIS. Nov 2023: Work stream 4 is the Hospital Dementia Friendly Charter, patient flow team have been invited to attend this meeting. There is also a audit perameter under the National Audit of Dementia. This will take a focused action as this aim is part if the wider hospitla admission and discharge work.	Nov 2023: This action needs to be part of the wider patient flow and discharge in ABUHB. Invites to the Dementia workstream 4 meetings will help us understand the challenges and solution and future measurements.	Nov 2023: Recorded and reviewing the membership of work stream 4 and action plan from the National Audit of Dementia.		31/03/2024
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Low	R4	Consideration should be given to formally monitor (e.g. set KPIs) and report on • patients hospitalised outside of their catchment areas; and • moved from one hospital site to another one over their treatment time.	Workstream 5b (measurement) will consider appropriate KPI's and will extend an invitation to the Patient Flow Team to be members of the workstream	01/08/2023	-7.97	31/10/2024			Overdue	Not Yet Due		March 2024: The Dementia Hospital Steering Group implements the All Wales Dementia Hospital Charter and as such are reviewing the KPI for measurement. The CWS Alert will help us to provide a framework to capture, admission, discharge, hospital moves and incidents. This Alert has been introduced in March 2024 and will be monitored and actions evolve as information is reviewed. The patient flow team have a regular invite to participate in the Dementia Hospital Steering Group. Nov 2023: Work stream 4 is the Hospital Dementia Friendly Charter, patient flow team have been invited to attend this meeting. There is also a audit perameter under the National Audit of Dementia. This will take a focused action as this aim is part if the wider hospitla admission and discharge work.				31/03/2024
Internal	2022.27	Dementia	Reasonab	Director of	Low	R4	Where operationally and clinically possible, a patient's locality should	Patient Flow Team to consider this specific aspect, linked to the	01/09/2023	-6.95	31/07/2024			Overdue	Not Yet Due		March 2024: Invitations have been sent to the Patient Flow Team to join the hospital dementia group. Still awaiting representation to be confirmed. Nov 2023: The Welsh language team are invited to the Dementia Workstream 4 Hospital Dementia group. The have a			Nov 2023: Pulse Welsh Language and engagement pages on the intranet as well	31/03/2024

Internal	2022.27	Services	le	Nursing	Low	R4	be considered as part of the admission / transfer process.	developed KPI's above	01/09/2023	-6.95	31/07/2024			Overdue	Not Yet Due	dedicated Pulse page to enable staff to access resources and information to support patients to communicate in the welsh language. the person centred team also have a dedicated e mail address and can signpost people to the the Welsh Language team.				as a Welsh Language team who we collaborate with closely.	31/03/2024
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Low	R4	There should be easily available information / training for staff to ensure patients can communicate with Welsh speaking staff.	The Workstream 4 (Hospital Charter) to link with the Welsh Language Lead and Workforce and Organisational Development leads to identify the number of Welsh Speaking Staff, identify how we can better identify Welsh Speakers and ensure access to Welsh Speakers as part of our Person Centred Care Dementia Care work programme.	01/09/2023	-6.95	31/08/2024			Overdue	Not Yet Due	March 2024: Colleague from the Welsh language team are members of the Dementia Hospital steering Group. Language preference and choice have been included on the patient bedside boards introduced to the COTE and medicine wards. The patient Experience and involvement Team are participating in the Cultural Competency accreditation programme to ensure all activities supported through the team consider cultural awareness and accessibility. Nov 2023: We have 15 wards who are adopting the VIP programme. We capture patient feedback and use patient experience to inform our improvments in care. recent example was the Anticipatory Grief learning module and Dementia Conference. The patient experience is an ongoing agenda item on our PCCT monthly team meetings. This information is included in QPS reports and annual reviews.			Nov 2023: We have 15 wards who are adopting the VIP programme. We capture patient feedback and use patient experience to inform our improvments in care. recent example was the Anticipatory Grief learning module and Dementia Conference. The patient experience is an ongoing agenda item on our PCCT monthly team meetings. This information is included in QPS reports and annual reviews.	31/03/2024
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Low	R5	Local initiatives with success stories should be channelled and discussed at existing forums.	Patient Stories are used at MDT learning events, at Board, through the Quality and Patient Safety Operational Group (QPSOG) and Board. Discussions have taken place within the Person-Centred Care Team to develop a digital portal for all patient stories. Listening and Learning is reported at QPSOG. There are also early discussions around establishing a Community of Practice for patient experience to share learning and celebrate success/best practice (September 2023). The Dementia Specialist Practitioner through the VIPS work will be key to sharing best practice/success stories across all hospital wards.	01/09/2023	-6.95	30/06/2024			Overdue	Not Yet Due	This is an ongoing action, monthly team meetings facilitate an opportunity to share feedback and consider how we use this feedback to influence practice and services. Patient feedback is used as a basis of QPS, Internal and external reporting. A 1 year reporting of VIPS will take place in April 2024.				31/03/2024
Internal	2023.02	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	Medium	R1	A timeline plan for the path to the closure of the case should be prepared and shared with all persons involved in the case, in order that participants can plan and prepare for their input and schedule time to do so.	A review of the complaint process will be undertaken following the OCP process to realign Quality Patient Safety resourses to the Nusing Directorate. A new Quality Patient Safety Manager has been appointed who will be responsible for the complaints process. Since period of review the PTR, Legal and QPS teams are aligning under one structure, this will bring together enchanced knowledge and skills of the PTR regulations, legal tests and required timelines. The new structure will triangulate the whole complaint process, beinging improved quality and timeliness to concern responses.	31/03/2024	0.00	30/09/2024			Overdue	Not Yet Due	March 2024: The OCP has now concluded on 9th February 2024. Centrailising all PTR teams to ensure PTR regulations are adhered to. Trajectory has been devised for all divisons the Health Board has comitted to be within the 75% Welsh Government target by September 2024.				31/03/2024
Internal	2023.02	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	High	R4	Current barriers that are leading to poor resolution target and complience rates require identification and resolution urgently.	An urgent review of any immediate barriers and quick winds will be undertaken. The PALS service was launched in November which will aim to resolve more complaints through early engagement with families	31/12/2023	-2.98	30/06/2024			Overdue	Not Yet Due	March 2024: The QPS resource centralised on 15th February 2024. We are in the process of reviewing and remapping the entire concerns pathway which will identify and address the barriers that are leading to poor complainc. The PALS service are now managing all grade 1 and 2 concens.				31/03/2024

Internal	2023.02	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	High	R6	Actions to address the circumstances that have led to individual complaints and those that have been identifed to address complaint themes through boarder learning pathways should be captired in actions plans. The delivery of the plans should be monitored by appropriate oversight groups.	Review all QPS resourses being undertaken via an OCP which will include learning.	31/12/2023	-2.98	30/09/2024			Overdue	Not Yet Due		March 2024: The organisational OCP has now concluded and the QPS teams have moved centrally. Job Titles and Descriptions are being reviewed to include Learning and Quality Improvement. Learning captured onto action plans and held on datix. QPS and divisional leads to be trained by ABCi team to become Quality Improvement Coaches via spread and scale approach. High level themes identified and learning and QI to focus on the specific themes and learning shared widely accross the organisation. Goverance reporting and assurance processes are under review ro ensure consistency accross the system. Listenting and learning operational group commenced March 2024. Listenting and learning framework under development. Will be completed End of May 2024. QI coaches training September 2024.				31/03/2024
Internal	2023.04	Buisness Continuity Planning; Final Internal Audit	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R1.1	Business continuity plans and associated documentation should be completed for all service areas within the Health Board. The Health Board may wish to incorpoarte this process with the wider opeartional risk management processes. There needs to be an accountability and escalation routes if such plans/actions cards not completed.	Recommendation accepted - the requirement for business continuity plans is within the Policy and BG planing guidance. The emergency planning team have plans in place to further engage with specific service areas. The new intranet repository will provide further information and will provide further information and will be established to monitor the progress of plans. The newly established EPRR group will be well suited to be the forum for escalation.	31/01/2024	-1.97	30/06/2024			Overdue	Not Yet Due		March 2024: All Divisions have been reminded of ther need to have their BC plans in place, each have a nominated lead. Guidance, templates and training/workshops are accessible to all areas to support developing plans. The repository in available on line and starting to be populated with plans produced. The first meeting of the EPRR Group has taken place with representation from all Divisions, the ToR identfy this as being a forum to review progress and escalate issues.		March 2024: Processes are in place but some Divisions are early in there development of plans - these will be monitored through the EP team and to the EPRR group		31/03/2024
External	2021.01EA	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Workforce & OD	High	R1	The Health Board should review the arrangements in place toensure that annual leave for all staff is accurately recorded and held centrally	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.	30/04/2022	-22.98	30/04/2025			Overdue	Not Yet Due		March 2024: "The Medical Workforce Rostering System will be implemented in the Health Board on a phased basis over an 18 month period. The absence management function of the new rostering system will enable the Health Board to record annual leave entitlements and will have a rolling balance of annual leave taken for individual doctors. The Health Board is in the process of setting up a new interface between ESR and Patchwork Rota to ensure all absence transfers from the new system to ESR. The implementation plan is being progressed and is phased by division and directorate. The plan is for the full implementation to be completed by April 2025. At that point all annual leave should be held on both erostering and ESR systems. The current medical annual leave policy is under review and a decision will be required before implementation on how annual leave will be recorded days/hours/sessions. " November 2023: Procurement completed. Draft Implementation plan being discussed with Divisional Directors. Roll out to commence in January 2024. Aug 2023: The roll out the newly procured workforce medical e-system will resolve the logging of annual leave centrally. Incremental implementation will progress once purchased. Current technical issues with procurement. If resolved implementation will commence October 23. Nov 2022 the roll out the newly procured workforce medical e-system will resolve the logging of annual leave centrally. Incremental implementation will progress over the next 9 months.	Aug 2023: Given current pressures on staff it is not felt that a interim system change of 12 months would be beneficial Cultural issue anticipated that it will take longer than June 2023 to realise in full. Given current pressures on staff it is not felt that a interim system change of 12 months would be beneficial Cultural issue anticipated that it will take longer than June 2023 to realise in full.	Aug 2023: Executive Team. Legal and Procurement advice	September/October 2023 for full implementation following procurement and implementation of the new data base.Ongoing evaluation of OT provision. Request extension to September/October 23.	31/03/2024
External	2022.03EA	Structured Assessment 2022	Not Rated	Director of Corporate Governance	N/A	R1	R1 Board and Committee agendas cause some meetings to overrun. The Health Board, therefore, should review Board and committee agendas to ensure meeting business can be covered in the time available whilst also allowing for sufficient scrutiny and discussion.	Ongoing development of the Board's Assurance Framework and Risk Management Framework will enable the Board and Committees to ensure focus on priority, risk-based, areas by exception, supported by risk-based workplans. The development of Board and Committee Etiquette and Conduct of Business will also support greater effectiveness of meetings.	01/09/2023	-6.95	31/05/2024			Overdue	Not Yet Due		March 2024 -A review of Board Business processes and products has been undertaken and the outcome of this work is included in an Improving Board Business action plan and report that will be submitted to a future Board meeting. In terms of practical application there is greater focus taken at agenda setting meetings to ensure that sufficient time is allocated to support the meeting agenda. November 2023: The HOBB is undertaking a review of all board processes and procedures to secure greater consistency of approach and to ensure that all regulatory and statutory requirements are addressed though an action plan to improve board buisness. This will include the timeliness of meetings and scope of papers for consideration.				31/03/2024
External	2022.03EA	Structured Assessment 2022	Not Rated	Director of Corporate Governance	N/A	R3	R3 There is limited use of patient and staff stories at Board. The Health Board should consider how it can increase and maximise the benefit of patient and staff stories in Board and committees to help centre and	A Digital Story Protocol for staff and patient stories is currently under development and once approved an electronic digital repository of stories will be created. Digital Story Telling training has been commissioned. The CIVICA Citizen Feedback System	31/03/2023	-12.00	31/12/2024			Overdue	Not Yet Due		March 2024: Digital Story repository now being considered on an all Wales basis. In the meantime, the Patient Experience Team will oversee all digital stories and manage in person attendance at Board. Where possible these will align to presented papers . June 23: A Patient Experience & Involvment Strategy has been developed which includes Digital Patient Narratives and Stories. A patient story has been presented at a Board Development Session and PQSOC this year. All Wales Experience Team reviweing. Review December 2024				31/03/2024

External	A	Assessment 2022	Rated	Nursing	N/A	R3	patient and staff stories in board and committees to help centre and focus meetings on the things that matter most, and to help triangulate this intelligence with formal agenda items.	now allows people to leave narrated stories. A selection of these will be played at the start of every Board meeting. The Executive Team will agree a programme of staff and patient stories that help triangulate intelligence with formal agenda items.	31/03/2023	-12.00	31/12/2024			Overdue	Not Yet Due	Update July 2023: The Digital Story Protocol is drfated but is now being revised due to recent decisions to support 'in-person' patient experiences at Board. To date, a patient story has been played at each Board during 2023. Additionally, digital stories are being used at listening and learning events and development days. There is all Wales discussion around a digital toolkit. The CIVICA system is being rolled out with a specific focus on supporting teams with training to retrieve their own data. Patient verbal narratives are not yet on the system. The first CIVICA report will be presented at Executive Team in September 2023.				31/03/2024
Internal	2024.01	Facilities - Jan 2024	Limited	Chief Operating Officer	High	R1.1	Management should set out what information should be formally monitored at each site, at an operational level. This information could include, stock balances, stock usage, footfall, food waste etc. To support this, consistent procedures should be implemented across the Health Board andshould be accessible to all staff.Once embedded, spot checks should be carried out on the stock management at each site and the results of these checks should be reported to the monthly Facilities meeting.	ACCEPTED. The following steps will be taken to address the issue: Standard Operating Procedures will be developed to detail each step of the new process. These processes will be shared with staff and be made accessible	29/02/2024	-1.02	30/04/2024			Overdue	Not Yet Due	March 2024: Processes have been developed however upon reviewing it has been decided to enhance further. Final documents scheduled to be completed and signed off w/c 8th April (due to annual leave of key people)				31/03/2024
Internal	2024.01	Facilities - Jan 2024	Limited	Chief Operating Officer	High	R1.7	Management should set out what information should be formally monitored at each site, at an operational level. This information could include, stock balances, stock usage, footfall, food waste etc. To support this, consistent procedures should be implemented across the Health Board andshould be accessible to all staff.Once embedded, spot checks should be carried out on the stock management at each site and the results of these checks should be reported to the monthly Facilities meeting.	ACCEPTED. The following steps will be taken to address the issue: The Head of Facilities will consider the potential benefit of software to improve the efficiency, effectiveness and accuracy of stock management processes. Options to be presented to the Divisional Director for decision	31/03/2024	0.00	31/05/2024			Overdue	Not Yet Due	March 2024: Following completion of the actions above and the assessment of benefits of any additional software any proposal will be presented by the Head of Facilities to the Divisional Director by mid May				31/03/2024
Internal	2024.01	Facilities - Jan 2024	Limited	Chief Operating Officer	High	R2	Management should implement a consistent approach to stock ordering. This process should be based on current footfall and patient numbers, provisions already in stock and the quantities required per portion from the All-Wales recipes. Management should then complete monthly spot checks to ensure the process is being adhered to. Stock ordering should then be reported at the monthly Facilities meetings to ensure senior management have view of any issues.	ACCEPTED. The following steps will be taken to address the issue:Actions set out in agreed management action for matter arising R1.1-1.7	31/03/2024	0.00	31/05/2024			Overdue	Not Yet Due	March 2024: R2-6 completed. Anticipated that remaining two recommendations will be completed by May 2024.				31/03/2024
Internal	2024.01	Facilities - Jan 2024	Limited	Chief Operating Officer	Medium	R5.2	Management should review the security arrangements at each site and if appropriate to do so, add additional security measures where required.	1 Review processes for staff access. To ensure that processes are in place to ensure all goods are secured and accessed in a controlled environment.	29/02/2024	-1.02	31/05/2024			Overdue	Not Yet Due	March 2024: Completed but but consideration of additional steps on specific sites including additional CCTV is now being scoped up and costed				31/03/2024

Internal	2024.01	Facilities - Jan 2024	Limited	Chief Operating Officer	High	R6.1	Management should review how they measure and monitor waste and ensure a consistent approach across all sites. There should also be consideration of the use of extended functionality within Synbiotix and / or the recording of food waste for management information.	Develop a process, in flow chart form, to effectively monitor food waste	29/02/2024	-1.02	06/04/2024			Overdue	Not Yet Due		March 2024: This action has been completed locally. We have taken the decision to hold off implementing this new process whilst we assess it against the new waste regulations due to be implemented on 6/4/24				31/03/2024
Internal	2024.01	Facilities - Jan 2024	Limited	Director of Strategy, Planning & Partnerships	Medium	R4.2	Management should update the Estates Strategy (or equivalent) for continued relevance to estates condition as appropriate.	Agreed – this forms part of forward work plan for the Planning, Population Health and Partnerships Committee.	31/03/2024	0.00	30/06/2024			Overdue	Not Yet Due		March 2024: mCapital priorisiation complete. Estate Strategy will follow org. strat.				31/03/2024
Internal	2024.01	Estates Condition - Jan 2024	Limited	Director of Strategy, Planning & Partnerships	High	R6	The effectiveness of escalation and oversight of capital and estates related risks should be reviewed, notably as to the Board and relevant committees.	At its meeting in January 2024, the Board approved its Revised Risk Management Framework which set out the revised hierarchy for risk management within the organisation, alongside an agreed Risk Appetite Statement. In-line with this Framework, the Head of Risk and Assurance will work with the Divisional Director of Estates & Facilities to review the risk management arrangements in place, ensureing appropriate escalation reporting from service to Board level.	31/01/2024	-1.97	31/05/2024			Overdue	Not Yet Due		"March 2024 - The Head of Corporate Risk and Assurance will work with Estates to ensure that their divisional risk register is robust and up to date, underpinned by operational risk reporting, and that it feeds the hierarchy process to CRR and SRR (in accordance with the framework). Furthermore, the Finance & Performance Committee is responsible for seeking assurance on estates compliance matters, which has been included in the committee workplan 2024/25 to ensure sufficient assurance is built in. "				31/03/2024

Appendix 5 - Overdue Recommendations Following Q4 Updates

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Priority	Recommendation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC Comittee	Final Report Deadline Status	Revised Deadline Status	If closed and not complete please provide justification	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close/complete the recommendation?	Reporting Date
Internal	2024	Facilities - Jan 2024	Limited	Chief Operating Officer	Medium	R7.4	Management should investigate the following system improvements and implement if appropriate: Bank: • the possibility of using the AllocateMe function within the Bank Staff system to create a better approach to allocating bank shifts to a wider pool of staff; • utilisation of Safe Care or Allocate to monitor when staff start and end their shift; and • the completion of the programme of work to prevent staff from completing all associated steps of approving and paying a bank shift.	Explore the use of safe care or alternative system to monitor staffs start and finish time this is part of the pre-enabling plan for the roll out Health Roster payroll drop down.	29/02/2024	-1.02		-1487.93		Overdue			March 2024: This has been explored. Unfortunately this is not possible at this stage. Other options are being explored				31/03/2024
Internal	2023	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	Medium	R5	Complaint case analysis detail level should be sufficently granular, to provide learning to recipients and to prevent reoccurance.	Review of all QPS resourses being undertaken via an OCP will include learning. A review of divisional QPS structures and asurance mechanisms will be require followng OCP this will form part of a wider delivery plan for the Quality Strategy and a clear accountability frameowrk between the ursing Directorate and the Operational Divisons for QPS.	31/12/2023	-2.98		-1487.93		Overdue			March 2024: The orgaisational OCP has now concluded and the QPS teams have moved centrally. Job Titles and Descriptions are being reviewed to include Learning and Quality Improvement. Learning captured onto action plans and held on datix. QPS and divisional leads to be trained by ABCI team to become Quality Improvement Coaches via spread and scale approach. High level themes identified and learning and QI to focus on the specific themes and learning shared widely accross the organisation. Goverance reporting and assurance processes are under review ro ensure consistency accross the system. Working with datix team to ensure that actions are assigned on the datix system.				31/03/2024
Internal	2022.3	Dementia Services	Reasonable	Director of Nursing	Medium	R2	There should be a programme of work implemented, to undertake an assessment of the environmental suitability of wards that provide beds for patients with dementia	This will be discussed at the In-Patient Hospital Group on 28th of June and confirm who leads on this	01/06/2023	-9.97		-1487.93	12/09/2023	Overdue	Overdue		March 2024: "OAMH dementia wards complete the Kings Fund audits on the three dementia wards. They are piloting the ABUHB Accreditation audits on Cedar Park which will be rolled out on al OAMH wards which include environmental audits. Ligature risk assessment audits are part of the ward OAMH yearly review. General hospital wards do not routinely use the Kings fund audits on wards, but the tool has been used to support individual ward improvement plans as part of the VIPS hospital dementia Friendly Hospital Charter implementation programme. UPDATE JULY 2023. Audit recommendations discussed at meeting. Agreement that a review of the in-patient action plan will be undertaken in September 2023. A dedicated inpatient workshop focussing on the All Wales Dementia Friendly Hospital Charter will be held in November 2023. This will include a review of the resources required to undertale an environmental audit of in patient wards.				31/03/2024
Internal	2022.2	Discharge Planning	Limited	Director of Nursing	Medium	R7	We recommend that the Health Board continue to analyse the reasons behind re-admissions within a suitable period of time. Where themes and trends are identified that these are investigated further	The analysis of readmission rates is acknowledged as being problematic, as without clinical input at the time of readmission, our current systems are unable to differentiate between a readmission for a reason connected to a prior episode of care, or one that relates to a completely different clinical scenario. CHKS, which is the national benchmarking solution choice for Wales looks at the number of patients who have been readmitted regardless of specialty, consultant, diagnosis etc. This makes any analysis difficult to interpret or perhaps meaningless. The planning department is currently working with clinical teams to develop a number of meaningful measures to determine and understand readmission trends, and to identify where improvement is required. A number of data viewers have been developed and can provide 'bespoke' data by request. Moving forward, these measures will be included within the outcome measures and QPS insights. The Health Board has dedicated services to address frequent or 'high impact' service users that are working across Divisional Boundaries to provide alternative pathways. There is also a workstream focusing on patients at high risk of readmission supported by Lightfoot data and linked to goals 1 and 2 of the 6 Goals for Urgent & Emergency Care programme.	01/10/2023	-5.97		-1487.93		Overdue	Overdue		March: There is work ongoing to streamline data analysis, to ensure data is more meaningful and will enable the monitoring of trends. The Executive Director of Nursing and Digital have a meeting to review this in April. Progress will be monitored on an ongoing basis via the Integrated Discharge Board. January 2024: A review of the data and audit requirements for discharge is planned, the systems and processes have been revised and data and audit opportunities can now be reviewed including case review				31/03/2024
Internal	2022.1	Records Managment	Limited	Director of Digital	Medium	R5	R5 The need for records management storage places should be regularly reviewed to ensure that sufficient spaces are available for record keeping purposes.	This issue is to be raised with the All Wales Medical Directors Forum as Caldicott Guardians. The Data Protection Officer will raise this at quarterly meetings with the Medical Director and agree an action plan.	31/12/2023	-2.98		-1487.93		Overdue			Mar 24- Closure of another library of records achieved at Llangennech and move of some mental health, children service records to vacated Antenatal Basement Library to relieve pressures. - Unable to provide a revised timescale at this stage.				31/03/2024

Appendix 6 - Completed Recommendations Following Q4 Updates

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Priority	Recommen-dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC Comittee	Final Report Deadline Status	Revised Deadline Status	If closed and not complete please provide justification and ensure evidence is avaliable	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close/complete the recommendation?	Reporting Date
Internal	2017.00	Health and Safety (2017/18)	Limited	Director of Therapies and Health Science	High	R1	R1 The Health Board should develop a methodology / approach for establishing and undertaking an annual programme of workplace inspections. In particular, it should set out: How service areas / wards are selected for an inspection, including risk analysis, previous findings, incidents and Datix reporting; the approach to the inspection, including which health and safety areas are included. For example, there may be numerous priorities from one year to the next; methodology for undertaking the inspection, i.e. the process for completing one from start to finish; how assurance is provided to the sub-committees of the Board over how the programme of work is devised and that it is completed on schedule or otherwise; and findings from the workplace inspections are identified and acted upon.In addition, the Health Board should ensure that a programme of workplace inspections is developed and delivered in accordance with section 10.1 of the Occupational Health and Safety Policy. For example, the Health and Safety Committee may stipulate that all high risk areas are reviewed each year. Furthermore, if the programme is delivered late, then the Committee should receive assurances, together with an action plan for delivery to be returned to schedule.	An ABUHB health and safety monitoringmanual will be developed. This will include a two year plan which outlines the audit/inspection delivery programme.The manual, including programme willbe presented at the ABUHB Health and Safety Committee in March 2018 for approval. The anticipated start date of the monitoring is 1stApril 2018.Future monitoring of the health and safety audit/inspection compliance will be presented via Divisional dashboards with an overview being presented at the ABUHB Healthand Safety Committee.	30/04/2018	-70.89	31/03/2024	0.00	12/09/2023	Completed/Closed	Completed/Closed		**March 2023** - A programme of respiratory protection equipment (RPE) inspections has been developed and commenced in October 2022. The plan to inspect all in-patient clinical areas by March 2023 is approximately 95% complete. The inspections conducted by the Corporate Health and Safety Department are recorded via the AMaT system enabling the outcomes to be analysed & reported to relevant forums i.e. Divisional QPS meetings, Site Management groups, ABUHB Health and Safety Committee, QPS Operational Group etc. A programme of health and safety environmental inspections will commence in May 2023 and will target clinical areas. The programme will be carried out over a two-year cycle, commencing with the older estate or those that have been subject to significant change i.e. Royal Gwent Hospital and Nevill Hall Hospital. The inspections will be conducted by the Corporate Health and Safety Department and recorded via the AMaT system enabling the outcomes to be analysed & reported to relevant forums i.e. Divisional QPS meetings, Site Management groups, ABUHB Health and Safety Committee, QPS Operational Group etc. The Corporate Health and Safety Department are also planning the development of self-assessment inspection tools for wards and departments to complete their own localised health and safety monitoring. This will support a programme of health and safety monitoring across the Health Board.	There are no identified barriers to implementing the revitalised plan of health and safety monitoring. Resources that were not previously available within the Corporate Health and Safety Department have now been established to ensure a sustainable system of monitoring.	The risk will reduce as the programme of health and safety monitoring is implemented.	March 2024: "50 Workplace Inspections (100% of the target) have been completed for all Inpatient areas at Acute Hospitals.The average compliance score for these inspections is 88.2%"	31/03/2024
Internal	2017.00	Health and Safety (2017/18)	Limited	Director of Therapies and Health Science	High	R2	R2 The Health Board should ensure that each area has completed an up-to-date health and safety risk assessment, by a trained co-ordinator. The risk assessment process should be overseen by the Health and Safety team, to ensure that it is completed in accordance with the Occupational Health and Safety Policy.In addition, the Health Board should review and refresh the list of safety co-ordinators and continue to do so following the initial update.The Health and Safety team should provide assurance and regular updates to the Health and Safety Committee over the status of risk assessments.	The monitoring of local risk management systems, including risk assessments will be included in the audit/inspection programme.The status of risk assessments will be reviewed and compliance reported via a dashboard to the ABUHB Health and Safety Committee and relevant Divisional forums.Further consideration is required to the utilisation of software to record and manage risk within the Health Board.	30/04/2018	1417.05	31/03/2024	1487.93	12/09/2023	Completed/Closed	Completed/Closed		**March 2023** - The Corporate Health and Safety Department have engaged with Divisions to ensure risks are recorded, monitoring and managed using the Datix system. This has improved the quality of health and safety risks on the system. The Corporate Health and Safety Department are reviewing all high risks (risk rating of 12 or above) recorded on the Datix system and where necessary support local managers to mitigate the risk. The programme of health and safety environmental inspections will support the identification and review of health and safety risks across the Health Board. Health and safety risks will be regularly reported to the ABUHB Health and Safety Committee to enable active monitoring. A revitalised education programme of health and safety risk assessment training has been approved and commenced in 2023. The register of risk assessors within the organisation has been reviewed and areas needing support will be prioritised for attendance at the risk assessment training.	The primary barrier to implementation would be lack of engagement from the areas / Divisions. Implementation of the new risk module in Datix Cymru could present a potential barrier.	The risk associated with the lack of health and safety risks will be reduced as areas engage with the risk assessment training and complete or update risks on the Datix system.	March 2024: "Implementation of a Health and Safety Risk Assessment Training programme for 2023/24. This has resulted in more than 200 additional risk assessors attending the training, therefore deeming them competent to complete the required health and safety risk assessments. Self Assessment form shared with Divisions to capture intelligence on health and safety risk management"	31/03/2024
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R4	R4 The risk identification process should be formally linked to the issue / event / problem management process in order to ensure that underlying risks are identified.	A review of risk management processes has commenced. The Health Board has appointed a Chief Nursing Information Officer/Clinical Safety Officer who will lead the project to align risk management processes from Programmes, design, Service Delivery, Health Records and Information Governance and Cyber Security to inform the new governance structure.	31/12/2021	1461.02		0.00	08/02/2024	Completed/Closed	Completed/Closed		March 24 - The directorate is following the newly published HB Policy and framework for risk management. A seperate review of datix is underway with a view to move all directorate risks to this format. A further audit has also commenced regarding risk management across digital.January 2024: Work is underway to align the directorates existing risk management framework with the updated Health Board framework and will be complete by the end of February. Any digital issue, events and problems are managed using well defined best practice and roles are in place within Digital Service Delivery to support this. The new directorate framework will outline how operational risks identified through day-to-day support activities are managed using Datix as the single source of information. Strategic plan to incorporate cascade trainers into the training provision to increase compliance.				31/03/2024
Internal	2021.07	Occupational Health	Substantial	Director of Workforce & OD	Low	R1	The Health Board should consider:a)Automating key aspects of the processes, to reduce the workload for the Occupational Health Team. For example, auto-generation of emails / letters for referrals, self-selection of referral appointmentsby staff or a self-directed referral to an appropriate professional.b)Updating resilience / continuity plans to assist with increased demand in the future, to include reallocation of team members, setting up amended work schedules, reduced appointment slots, allocation of clerical staff to clinical staff to maximise clinic availability, overtimeoptions, re-focussing of service prioritiesand / or streamlining of processes to a bare minimumon a temporary basisetc.c)Engaging in any future All-Wales reviews of occupational health serviceswithin the NHS.	a.It is planned that the current management referral process will move from paper referral and Occupational Health response in letter format to an online referral system and subsequent report to managers in 2022. The service is currently part of an All Wales task and finish group developing this. Once implemented it should remove several administration stages of the current process. The recommendation for staff to be able to self–select would miss out the essential clinical triage process to allocate Occupational Health clinical staff resources appropriately. b.Occupational Health consistently review its skill mix and resources to meet the demands of the service. Through periods of higher administration demand for example Covid 19 PCR results and the annual Flu programme additional administrative hours are sourced. This reduces any impact on routine Occupational Health function. A detailed service review is planned for Quarter 2 in 2022 which will incorporate the recommendation of the Occupational Therapy scoping exercise which commenced on the 1st November and is planned to conclude on March 31st2022. Health function. A detailed service review is planned for Quarter 2 in 2022 which will incorporate the recommendation of the Occupational Therapy scoping exercise which commenced on the 1st November and is planned to conclude on March 31st 2022.	31/03/2022	1463.97		0.00	12/09/2023	Completed/Closed	Completed/Closed		Aug 2023: A new automated system OPASG2 is coming in on 20th September which will bring the following benefits in addition we are engaging with all Wales review and systems procurement. Applicants complete an online pre-employment health declaration – removal of paper forms! Integrated functionality between OPASG2 and the Trac recruitment system. Therefore, OH results update the applicant record directly in Trac. Transparency of applicant progress with timely updates visible in Trac such as an OH appointment booking. Reduced waiting times for Occupational Health Clearances	Aug 2023: Lessons learned from early implementers (Swansea)any any further potential dealys on an all Wales basis. Sep 2022 Awaiting decision regarding the new All Wales Occupational Health database. This has been put on hold until Spring 2023 . With regards OT implementation awaiting expressions of interest	Aug 2023: Executive team. Comprehensive training package Ongoing review of skill mix and resources to meet the deamands of the service .	"New automated system OPASG2 installed in September 2023. There is no longer a requirement for new employees to complete paper pre-employment health questionnaires as this is now via an online link. The integration between OPASG2 and Trac allows for fitness for post outcomes to be record directly in Trac. Recruitment services are able to see what step each individual is in the process reducing the need for phone calls, emails etc. Manager referrals are also via an online link and referring managers are able to to log into their account and see what stage their employee is at e.g. awaiting triage, awaiting an appointment to be sent, the appointment date etc. The new system has reduced the steps in adminisrtrive processes."	31/03/2024
Internal	2021.17	Corporate Governance: BAF	Reasonable	Director of Corporate Governance	Medium	R4	R4. We recommend that the Health Boarddevelops a periodic report commenting on compliance/ the effectiveness of the BAFprocessand reports this to an appropriate committee.	The Health Board accepts this recommendation and will incorporate a review of the effectiveness of the BAF into Board evaluation and committee self assessment processes.	31/07/2022	1467.97	31/03/2024	1487.93	12/09/2023	Completed/Closed	Completed/Closed		August 2023: Risk Management Stratgey and Board Assurance Framework processes under review. Revised strategy due to Board in Q4, 2023/24.			The Board reviewed and refreshed its strategic risks in June 2023, as part of that refresh the creation of a Strategic Risk Register (SRR) has been established (Board Assurance Framework [BAF]). The risks that form the SRR are aligned to the delivery of the IMTP and the Health Board's strategic and annual objectives. Regular reporting to the Board and sub-Committees of the Board has been in place since the refresh in June 2023. The Board receives the Risk Management and Assurance Report at every meeting as well as the Audit, Risk and Assurance Committee. Other sub-committees of the Board receive a Committee Risk and Assurance Report for the strategic risks for which it is responsible. In addition, any high-level operational risks that are included on the Corporate Risk Register (CRR) are reported to the relevant committee and to the Audit, Risk and Assurance Committee and the Board for oversight. This new approach ensures that the Board is sighted on all strategic and corporate risks that have the potential to impact delivery of the Health Board's objectives. In addition, the Risk Management Framework has been rewritten and a Risk Management Policy and Procedure has been developed to ensure greater transparency on the role of risk management, as well as how the risk management processes	31/03/2024

Internal	2022.01	CYP Continuing Care	Reasonable	Chief Operating Officer	High	R1	CloseHealth Board monitoring ofthe key risks facing the CCNS to ensure:•appropriate action continues to be taken; and•support is provided to the CCNS as required	1)Engagement with families and staff in a review of service models –utilising co-production and with a compassionate leadership lens explore options of "out of family home" models of care, which may meet needs of child/young person more effectively, optimise management of scarce resources and support retention of staff.2)Workforce review to identify skill mixedworkforceresource required to deliver safe service across the various linesof commissioned service e.g.Continuing Care, Special Schools, Children's Out Patients, Clinical/Care closer to home3)Business Case/Service Review to establish options of further efficiency and priority with theidentification ofdiscrete financialbudgetlinesto meet assessed and agreed service priorities4)Developing new roles/skill mix within the Children's Community Nursing Service to enhance service provision5)Partnership Board/Welsh Governmentrecommendation required to determine the prudent delivery of care described as ancillary and incidental care needs, and multi-agency responsibilities initsdelivery.This will aid the alignment of Value-Basedhealth care and Value-Based social care	31/03/2023	1475.93	31/12/2023	1484.95	12/09/2023	Completed/Closed	Completed/Closed		March 2024: 1. Out of home model of care on hold with a review of modelling and running of Bridgeview . 2.Succesful recruitment drive has taken place over the last 12 months with staffing almost at full establishment. In addition the CCNS have built a pool of bank staff with the appropriate skills to support respite in times of sickness absence. 3. Band 4 JD and scope of practice written and agreed with head of nursing education and workforce. To be implemented into practice 2024/25 which will create a sustainable workforce that will develop our future nurses. 4. Joint health and social care meetings arranged to look at how we can make the best use of both services to meet the needs of our children and young people.Aug 2023: Awaiting sign off of Bridgeview before we can engage with our families to explore out of home model of care. 2. Workforce review completed and skill mixed model identified. Awaiting sign off of Band 4 before implementation. 3. Business case submitted detailing risks of service reduction in each area. New financial envelope was estimated from a period of high vacancies, high sickness and complaints from families due to a reduction in their statutory respite. 4. Currently no scope to develop new or additional roles within the CCNS due to financial constraints, however skills mix model has been developed through the workforce work to enhance the skills and allow a "grown our own" model for sustainability in the future of the service. 5. Ongoing discussions due to social care and health interperating the recommendations differently.	Aug 2023: Bridge view sign off. Agreement and sign off of Band 4 Senior Health Care Support Workers. Differing interperation of goevernmenet recommendations from health and social care		March 2024: CCNS has undergone admirable recruitment drive and have attracted both HCSW and RN to the service. The current model is being delivered in its fullest capacity with very little dependency on agency. Pool of bank staff developed to support in the absence of permanent staff. Band 4 JD agreed and to be recruited to. Future meetings arranged for collaboration between LA and HB to meet the needs safely and appropriately without delaying any care to our children and young people	31/03/2024
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Medium	R5	The Health Board should consider the purchase of additional robot capacity.	The business case for submission in Q4 provides an option also to increase capacity of automation.	01/03/2023	1474.95		0.00	28.11.2023	Completed/Closed	Completed/Closed		Nov 23: Dependent on recruitment of of resources for RPA Aug-23: RPA escalation SBAR presented to Exec Board in March 2023. Additional robot purchase not supported pending rebaselining of planned automations benefits			Mar 24 - additional robot capacity has been put in place on a case by case basis where digital workers have been required to solve issues e.g. PSA, Maternity & Medilogik. The service has secured 3 additional robots for 2024/25.	31/03/2024
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Medium	R6	Consideration should be given to increasing the level of ring fencing for specific robot time for time constrained processes as part of the ongoing development of the RPA service	The business case for submission in Q4 provides an option also to increase capacity of automation.	01/03/2023	1474.95		0.00	28.11.2023	Completed/Closed	Completed/Closed		Nov 23: Dependent on recruitment of of resources for RPA Aug-23: Peak day time capacity consumes all current robot capacity. Additional robots have been procured from non RPA budgets to support critical functionality. The RPA architect continues to reprofile activity to ensure automations are deployed optimally to allow additional automations not dependent on in hours working to be undertaken.			Mar 24 - ring fencing is in place for robots where necessary e.g. finance however, robots can be utilised flexibly and it is best practice to sweat the asset where time is available within a robot's schedule of work to deliver activity	31/03/2024
Internal	2022.17	Risk Management	Reasonable	Director of Corporate Governance	Low	R2	The Health Board should clarify how Divisions will record risk in the meantime.	The Health Board is currently revising its Risk Management Policy which is expected to be presented for endorsement at the May 2023 Board meeting. Within the revised Strategy, refined guidance on capturing and recording of risks will be included.	01/05/2023	1476.95	31/03/2024	1487.93	12/09/2023	Completed/Closed	Completed/Closed		March 2024 - The Board approved the Risk Management Framework and Policy at its meeting in January which provides a clear process for identifying, managing ad recording risks. This is strengthened by the Head of Corporate Risk and Assurance meeting with divisions to provide training on the Health Board approach			Risk Management Framework and Policy have been published on the staff intranet site and on the ABUHB website. In addition the development of risk registers is seeing movement of risk between all levels of the the escalation process.	31/03/2024
Internal	2022.18	Monitoring Action Plans	Reasonable	Director of Therapies and Health Science	Medium	R1	A SOP for how to manage and respond to HSE reports should be created. It should include, but not limited to: • how HSE reports are distributed to responsible staff within the Health Board; • who has designated responsibility for coordinating responses to HSE reports; • the escalation process for issues identified as part of HSE inspections; • who/which committee has responsibility for monitoring actions raised as part of the HSE reports and the process for doing this; and • when assurance reports should be produced and which committee should review them	The Health Board agrees with this recommendation. An SOP on the management of HSE reports will be developed and presented to the ABUHB Health and Safety Committee in May 2023	01/05/2023	1476.95	29/02/2024	1486.92	08/02/2024	Completed/Closed	Completed/Closed		January 2024: The development of an All Wales SOP on the management of HSE reports has stalled, therefore the Health Board have developed a Draft SOP which is currently awaiting approval August 2023: The development of an SOP on the management of HSE reports is being discussed at a national level via the All Wales Health and Safety Management Group. Following discussion at the natiional meeting in September 2023 an SOP will be prepared and shared with members of the Health and Safety Committee to share across the Health Board.			March 2024: Standard Operating Procedure (SOP) in relation to the Management of Health and Safety Executive (HSE) Inspections and Reviews shared with Health Board Senior Managers	31/03/2024
Internal	2022.20	Tredegar Health & Wellbeing	Limited	Chief Operatin	Low	R6	Quantified, measurable and achievable targets should be set to appraise project benefits	The Benefits register will be updated to reflect quantified targets as	01/06/2023	1477.97		0.00	08/02/2024	Completed/Closed	Completed/Closed		March 2024: Benefits Realisation Plans (BRP) dashboard is progressing. BRP presented at February Project Board		N/A	Aug 2023: Updated BRP	31/03/2024

l	2022.20	Centre Final Internal Audit Report	Limited	Operating Officer	Low	R0	Quantified, measurable and achievable targets should be set to appraise project benefits.	at the end of March 2023.	01/06/2023	1477.97		0.00	08/02/2024	Completed/Closed	Completed/Closed	Jan 2024: Has been discissed at Project Board but not finalised Aug 2023: This needs discussion at the newly constituted Project Board			N/A	Aug 2023: Updated BKF	31/03/2024
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R5	At future projects Contracts should be executed prior to the commencement of works / duties.	Agreed -Future Projects Contracts will be signed prior to the commencement of works	01/03/2024	1486.95		0.00		Completed/Closed	Completed/Closed	March 2024: No new contracts/works have commenced. Derogations were signed off by the pervious Head of Operations. VT signed off design proposals and the scrutiny process required input from Shared Services to the technical design. Discussion could not place with the Linac Supplier until after FBC submission and this has subsequently led to a number of reviews of the Bunker Layouts.			This has not delayed project progress	March 2024: There is currently a process in place to facilitate the signing of contracts. The contractor will deliver the signed copies of the contract to HQ, the contract is recorded, signed and sealed. One copy of the contract is retained in HQ the other posted back or collected by contractor.	31/03/2024
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Low	R5	At future projects All contracts should be dated	Agreed - Future Projects - Contracts will be dated.	01/03/2024	1486.95		0.00		Completed/Closed	Completed/Closed	March 2024: No new contracts/works have commenced.At this point in time the process for the provision of collectoral warranties has not required to be actioned as the relevant works have not be completed			N/A	March 2024: Works are completed, Contractor forwards 3 copies of warranty for are prepared, 1 for AB, 1 for Contractor - 1 for subcontractor.	31/03/2024
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R5	All contracts over £100k in value should be signed by both the Chief Executive & Chair in accordance with the UHB's Standing Orders (Scheme of Delegation)	Agreed - Future Projects Contract Values exceeding £100k will be signed by the Chief Executive & Chair in accordance with UHB Standing Orders.	01/03/2024	1486.95		0.00		Completed/Closed	Completed/Closed	March 2024: All future projects exceeding £100k will follow the agreed process in accordance with UHB Standing Orders.				March 2024:Standing Orders.	31/03/2024
Internal	2022.26	Contract Mangement	Reasonable	Chief Operating Officer	High	R1	We recommend that Health Board management ensure that a contract management policy and guidance is developed, approved, issued and communicated to all relevant staff. It should incorporate the following: 1. guidance over the operational management responsibilities associated with contracts, including the management / identification of contract risks, performance monitoring, escalation of matters arising etc.; 2. template documents to record details of how individual contracts are to be managed e.g. responsibility for oversight and delivery. This is particularly important where the responsibility lies across different functions within the Health Board; 3. the All Wales Procure to Pay e-Manual, issued by NWSSP Procurement includes a section on implementation and contract management processes and provides information that should be aligned to any position developed by the Health Board; and 4. the Procurement Policy and Financial Control Procedure is updated to incorporate any relevant references as a result of the above changes.	A contract Management Policy is in the process of being developed and due to be drafted by the end of July 2023 for consideration and approval by end August 2023. The policy will make reference to standard documentation in order to standardise the approach to contract management across the Health Board, and form a FCP	01/08/2023	1479.97		0.00		Completed/Closed	Completed/Closed	March 2024: The contract managemnet financial Control procedure has been signed off by both the Executive Board and Audit Committee and training has commenced with Divisional representatives which will continue through until the end of May. The FCP will become live from April 1st 2024. January 2024: A contract management Financial Control Procedure has been developed is is due to be presented to the Executive Board in the form of an SBAR. The final version is being retified by the Finance team before it goes to the Executive Board and then Audit Committee.				March 2024: The contract managemnet financial Control procedure has been signed off by both the Executive Board and Audit Committee and training has commenced with Divisional representatives which will continue through until the end of May. The FCP will become live from April 1st 2024.	31/03/2024
Internal	2022.26	Contract Mangement	Reasonable	Chief Operating Officer	Medium	R1	The introduction of contract management guidance and policy should be supported by the roll out of an appropriate training programme to all relevant staff, to assist with the embedding of the agreed approach.	Once the Policy is finalised a training programme will commence for all contract managers delivered by the Head of Procurement and Assistant Head of Procurement, supported by the Divisional Finance Business Partners	01/12/2023	1483.97		0.00		Completed/Closed	Completed/Closed	March 2024: The contract managemnet financial Control procedure has been signed off by both the Executive Board and Audit Committee and training has commenced with Divisional representatives which will continue through until the end of May. The FCP will become live from April 1st 2024. January 2024: A contract management Financial Control Procedure has been developed is is due to be presented to the Executive Board in the form of an SBAR. The final version is being retified by the Finance team before it goes to the Executive Board and then Audit Committee.				March 2024: The contract managemnet financial Control procedure has been signed off by both the Executive Board and Audit Committee and training has commenced with Divisional representatives which will continue through until the end of May. The FCP will become live from April 1st 2024.	31/03/2024

Internal	2022.26	Contract Mangement	Reasonable	Chief Operating Officer	Medium	R2	We recommend that Health Board management ensure that: a. A repository of all signed contractual documentation is established to include: all contract schedules, framework agreements, service level agreements, call off orders etc. b. The repository is placed on a shared platform such that it is accessible to all relevant staff / stakeholders.	This is difficult as Procurement services who maintain the bulk of any contract documentation sits under NWSSP who have their own architecture within SharePoint which is not readily accessible to Health Board staff. It is proposed in the contract management policy that a contract management plan will be drafted between procurement and the responsible division/contract manager with information to be issued back to procurement at regular intervals. This will ensure that all contract documentation is kept in one place and is accessible by contacting the procurement team.	01/12/2023	1483.97		0.00		Completed/Closed	Completed/Closed	March 2024: The contract managemnet financial Control procedure has been signed off by both the Executive Board and Audit Committee and training has commenced with Divisional representatives which will continue through until the end of May. The FCP will become live from April 1st 2024. January 2024: A contract management Financial Control Procedure has been developed is is due to be presented to the Executive Board in the form of an SBAR. The final version is being retified by the Finance team before it goes to the Executive Board and then Audit Committee.			March 2024: The contract managemnet financial Control procedure has been signed off by both the Executive Board and Audit Committee and training has commenced with Divisional representatives which will continue through until the end of May. The FCP will become live from April 1st 2024.	31/03/2024
Internal	2023.02	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	Medium	R2	All investigation evidence should be attached to the complaint Datix record for ease of referance in the event of queries.	A review of the complaint process will be undertaken following the OCP process to realign Quality Patient Safety resourses to the Nusing Directorate. A new Quality Patient Safety Manager has been appointed who will be responsible for the complaints process. Since period of review the PTR, Legal and QPS teams are aligning under one structure, this will bring together enchanced knowledge and skills of the PTR regulations, legal tests and required timelines. The new structure will triangulate the whole complaint process, beinging improved quality and timeliness to concern responses.	31/03/2024	1487.93		0.00		Completed/Closed	Completed/Closed	All evidence is now attached to the complaint Datix record for ease of reference in the event of queries. A plan for quality assurance checks will be undertaken to review 10 records per month.			All evidence is now attached to the complaint Datix record for ease of reference in the event of queries. A plan for quality assurance checks will be undertaken to review 10 records per month.	31/03/2024
Internal	2023.02	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	Low	R3	Complex complaint cases which under the regulations are permitted an investigation period of up to six months should be excluded from the 30 day breach statistics.	Welsh Government are currently reviewing PTR regulations.	31/01/2024	1485.97		0.00		Completed/Closed	Completed/Closed	All Health boards have contrubited to reviewing the new PTR regulations. This is consuered by the Health Board when a complaint is over 30 days.			This has been completed from a Health Board perspective, however this does not change the Welsh Government target at this stage.	31/03/2024
Internal	2023.02	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	Medium	R7	Actions to review the current structure throughout the Health Board mapped to the end to end process. Where gaps in or additional resourse requirements are identified these should be implemented to meet the requirements of the Health Board.	Review of all QPS resourses being undertaken via an OCP.	31/12/2023	1484.95		0.00		Completed/Closed	Completed/Closed	March 2024: The OCP has now concluded and the QPS team has now moved centrally.			The OCP has now concluded and the QPS team has now moved centrally.	31/03/2024
Internal	2023.04	Buisness Continuity Planning; Final Internal Audit	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R1.2	Buisness continuity plans/action cards should be regularly tested, to ensure steps taken are the most effective. Following a continuity event test being completed, lessons learnt and updates to the documentation should be completed.	Reccomendation accepted - This is included within the policy and buisness continuity planning guidance. Outcome from exercises and tests can be added too the repository and monitored by the emergancy planning team and be avaliable to share with others for learning and via the EPRR group.	31/01/2024	1485.97		0.00		Completed/Closed	Completed/Closed	March 2024: Exercises and tests are part of the BC process, as plans are developed local exercises are being supported to test activity. Learning from local and national exercises will be in cluded on the repository. A MI exercise is planned for 20 June 2024. A facilty established, a scenario developed and planning for the exercise ongoing. MI learning objectives and local service objectives have been identifed			March 2024: Processes are in place but some Divisions are early in there development of plans - these will be monitored through the EP team and to the EPRR group	31/03/2024
Internal	2023.04	Buisness Continuity Planning;	Reasonable	Director of Strategy, Planning	Medium	R3	Buisness continuity should be promoted throughout the Health Board on a regular basis, to	Recommendation accepted - Emergency planning promote buisness continuty on the intranet and to service leads, this wil be increased by quarterly updates on the intranet, using AB Pulse and with support	31/01/2024	1485.97		0.00		Completed/Closed	Completed/Closed	March 2024: This is happening via reminders on the intranet via AB Pulse and specific work with Divisions, also direct contact with thise who require training updates			March 2024: Policy has been updated and is in place and	31/03/2024

l	2023.04	Final Internal Audit	e	Planning & Partnerships	Medium	R2	help raise awareness throughout all service areas	by quaterly updates on the intranet, using AB Pulse and with support from the communication team across other internal media platforms and through the EPRR group and the BC group.	31/03/2024	1485.97		0.00		Completed/Closed	Completed/Closed	work with Divisions, also direct contact with thise who require training updates. Training records are held by the EP team.			exercises are ongoing	31/03/2024
Internal	2023.04	Buisness Continuity Planning; Final Internal Audit	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R2.1	The training resourse on ABUHB Sharepoint should be clearly signposted so staff know what the team delivers and what training they will need either on buisness continuity or major incident.	Recommendation accepted - promote and signpost services to the guidance viw the intranet and using the EPRR and BCM group. The repository will be in place by Dec 2023, easily accessed via the front page of AB Pulse and agree a weekly promotion of teh link with the comms team for the first month, and then quaterly as per R2	31/12/2023	1484.95		0.00		Completed/Closed	Completed/Closed	March 2024: This is happening via reminders on the intranet via AB Pulse and specific work with Divisions, also direct contact with thise who require training updates. Training records are held by the EP team.			March 2024: Training plan and records in placein place, regular reminders go out via Pulse	31/03/2024
Internal	2023.04	Buisness Continuity Planning; Final Internal Audit	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R2.2	There should be regular monitoring of training delivery by the Emergency Planning Team to ensure staff have the appropriate knowledge.	This will be identified by through the tracker. The summary tracker will capture training, meetings, exersise and workshops, this wil sit within the repsoitory.	31/12/2023	1484.95		0.00		Completed/Closed	Completed/Closed	March 2024: A tracker is being established to monitor all BC/MI training and activity - this will be reported into the EPPR group			March 2024: Policy has been updated and is in place and exercises are ongoing	31/03/2024
Internal	2023.04	Buisness Continuity Planning; Final Internal Audit	Reasonable	Director of Strategy, Planning & Partnerships	Low	R3	The Emergency Planning Team should undertake a "deep dive" of the information received on the Buisness continuity Resillence Day and implement any improvement actions required.	Recommendation accepted - The emergency planning team, divisons and directorates will continue to undertake debriefs following exercises and events to identify learning. Plans and actions card will be ammended according following this process. These will be shared via the BCM nad EPRR group as appropriate. The EP will develop a bespoke BC debrief workshop for Spring 2024	31/03/2024	1487.93		0.00		Completed/Closed	Completed/Closed	March 2024: The information from the Resiliance Day is now incortporated in to guidance and training			March 2024: Tracker, EPRR Group	31/03/2024
Internal	2023.04	Buisness Continuity Planning; Final Internal Audit	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R4	The Health Board should ensure that operational areas incorporate best practice, learning, lessons and other experiences from the pandemic within their buisness continuity plans.	Recommendation accepted - The BC guidenace incorporates debrief requirement to identify lessons to inform planning, this will be ammended to incorporate learning from the pandemic. An updated version will be shared with BC leads highlighting this requirement to be incorporated in new plans and current plans to be reviewed to ensure learning is included. This will be highlighted in all training and at the BC group meetings. This will also be monitored on the summary tracker reported inot the BC and EPRR group as part of the planned monitoring process.	31/12/2023	1484.95		0.00		Completed/Closed	Completed/Closed	march 2024: Post COVID activity is now BAU for areas therefore all BC plans being developed are based on changed ways of working			March 2024: Incorporated in guidance and training undertaken by team	31/03/2024
Internal	2024.01	Facilities - Jan 2024	Limited	Chief Operating Officer	High	R1.2	Management should set out what information should be formally monitored at each site, at an operational level. This information could include, stock balances, stock usage, footfall, food waste etc. To support this, consistent procedures should be implemented across the Health Board andshould be accessible to all staff.Once embedded, spot checks should be carried out on the stock management at each site and the results of these checks should be reported to the monthly Facilities meeting.	ACCEPTED. The following steps will be taken to address the issue: Each member of staff involved in the management or delivery of stock takes will be provided with training detailing the correct methods to use.	31/03/2024	1487.93		0.00		Completed/Closed	Completed/Closed	March 2024: All sites currently training staff, on course for completion by end of March				31/03/2024

Internal	2024.01	Facilities - Jan 2024	Limited	Chief Operating Officer	High	R1.3	Management should set out what information should be formally monitored at each site, at an operational level. This information could include, stock balances, stock usage, footfall, food waste etc. To support this, consistent procedures should be implemented across the Health Board andshould be accessible to all staff.Once embedded, spot checks should be carried out on the stock management at each site and the results of these checks should be reported to the monthly Facilities meeting.	ACCEPTED. The following steps will be taken to address the issue: Monthly stock takes wil take place at each site following the process set out in the Health Boards Financial Cotrol Procedure: Stores and Stocks.	31/03/2024	1487.93		0.00		Completed/Closed	Completed/Closed	March 2024: Stock take 1 was undertaken in February 24, monthly stocktakes are now scheduled				31/03/2024
Internal	2024.01	Facilities - Jan 2024	Limited	Chief Operating Officer	High	R1.4	Management should set out what information should be formally monitored at each site, at an operational level. This information could include, stock balances, stock usage, footfall, food waste etc. To support this, consistent procedures should be implemented across the Health Board andshould be accessible to all staff.Once embedded, spot checks should be carried out on the stock management at each site and the results of these checks should be reported to the monthly Facilities meeting.	ACCEPTED. The following steps will be taken to address the issue: Stock usage (patient orders and retail sales) will be monitored to track stock balances, and to ensure that provision orders align with all menus and match forecasted demand. Monthly Synbiotix data to be sent to senior FM managers of non-compliance with agreed provisions.	29/02/2024	1486.92		0.00		Completed/Closed	Completed/Closed	March 2024: Stock usage is being monitored and reports and any discrepancies were discussed in the the Facilities Management Team (FMT) meeting in March				31/03/2024
Internal	2024.01	Facilities - Jan 2024	Limited	Chief Operating Officer	High	R1.5	Management should set out what information should be formally monitored at each site, at an operational level. This information could include, stock balances, stock usage, footfall, food waste etc. To support this, consistent procedures should be implemented across the Health Board andshould be accessible to all staff.Once embedded, spot checks should be carried out on the stock management at each site and the results of these checks should be reported to the monthly Facilities meeting.	ACCEPTED. The following steps will be taken to address the issue: Local management teams will report on stock levels, food waste (production, unserved, and damaged stock) at the monthly Facilities Management Team meeting (chaired by the Head of Facilities	31/03/2024	1487.93		0.00		Completed/Closed	Completed/Closed	March 2024: Reports discussed at FMT in March This will continue as 'business as usual'				31/03/2024
Internal	2024.01	Facilities - Jan 2024	Limited	Chief Operating Officer	High	R1.6	Management should set out what information should be formally monitored at each site, at an operational level. This information could include, stock balances, stock usage, footfall, food waste etc. To support this, consistent procedures should be implemented across the Health Board andshould be accessible to all staff.Once embedded, spot checks should be carried out on the stock management at each site and the results of these checks should be reported to the monthly Facilities meeting.	ACCEPTED. The following steps will be taken to address the issue: Facilities Managers will provide assurance at monthly Facilities Management Team meetings that all provision orders match forecasted demand	29/02/2024	1486.92		0.00		Completed/Closed	Completed/Closed	March 2024: Reports discussed at FMT in March This will continue as 'business as usual'				31/03/2024
Internal	2024.01	Facilities - Jan 2024	Limited	Chief Operating Officer	High	R3.2	Frequent stock takes should be undertaken, to ensure any stock discrepancies can be investigated, in accordance with the principles of the Financial Control Procedure: Stores and Stocks.Any discrepancies should be investigated immediately and where discrepancies cannot be resolved this should be raised with senior management. Where minimum and maximum stock levels are in place this should be reviewed to ensure they are still appropriate following the pandemic, alongside the reduction in footfall within the canteen and following pricing updates.	ACCEPTED The following steps will be taken to address the issue:A process for reporting, investigating and escalating discrepancies will be developed and implemented in 'flow chart' form.	29/02/2024	1486.92		0.00		Completed/Closed	Completed/Closed	March 2024: Now completed				31/03/2024
Internal	2024.01	Facilities -	Limited	Chief Operating	High	R3.3	Frequent stock takes should be undertaken, to ensure any stock discrepancies can be investigated, in accordance with the principles of the Financial Control Procedure: Stores and Stocks.Any discrepancies should be investigated immediately and where discrepancies cannot be resolved this should be raised with senior management. Where minimum and	Initiate a review of current minimum and maximum stock levels to ensure that they remain accurate, then either: • Update the required minimum and maximum levels, alongside a	29/02/2024	1486.92		0.00		Completed/Closed	Completed/Closed	March 2024: Now completed				31/03/2024

l	2024.01	Jan 2024	Limited	Operatin g Officer	High	R3.3	maximum stock levels are in place this should be reviewed to ensure they are still appropriate following the pandemic, alongside the reduction in footfall within the canteen and following pricing updates.	• Update the required minimum and maximum levels, alongside a process for regular review, or • Use software to determine stock levels/required orders	29/02/2024	1486.92		0.00		Completed/Closed	Completed/Closed	March 2024: Now completed				31/03/2024
Internal	2024.01	Facilities - Jan 2024	Limited	Chief Operating Officer	Medium	R4.1	Management should review the processes in place for receiving the delivery of stock and implement a consistent approach across each site. For example, a comparison between the delivery and the order sheet. Where the ordering and receipting process happens within different departments, management should ensure all staff are aware of their responsibilities.When stock is signed as accepted and correct, but stock errors continue to be accepted, management should investigate these occurrences and undertake appropriate action.	ACCEPTED. The following steps will be taken to address the issue: 1. Review and update processes for the receiving and delivery of stock. A single process will be developed and implemented across each of the Health Board sites.	29/02/2024	1486.92		0.00		Completed/Closed	Completed/Closed	March 2024: Now completed				31/03/2024
Internal	2024.01	Facilities - Jan 2024	Limited	Chief Operating Officer	Medium	R4.2	Management should review the processes in place for receiving the delivery of stock and implement a consistent approach across each site. For example, a comparison between the delivery and the order sheet. Where the ordering and receipting process happens within different departments, management should ensure all staff are aware of their responsibilities.When stock is signed as accepted and correct, but stock errors continue to be accepted, management should investigate these occurrences and undertake appropriate action.	2. The responsibilities of each person involved in the stock ordering, receipting, delivery and management process will be reviewed and clearly detailed. All people involved in the new process will be provided training	29/02/2024	1486.92		0.00		Completed/Closed	Completed/Closed	March 2024: This action has been completed on each site but the Divisional Catering Team are now reviewing to ensure consistent approaches across whole Division				31/03/2024
Internal	2024.01	Facilities - Jan 2024	Limited	Chief Operating Officer	Medium	R4.3	Management should review the processes in place for receiving the delivery of stock and implement a consistent approach across each site. For example, a comparison between the delivery and the order sheet. Where the ordering and receipting process happens within different departments, management should ensure all staff are aware of their responsibilities.When stock is signed as accepted and correct, but stock errors continue to be accepted, management should investigate these occurrences and undertake appropriate action.	3. Implement a system to monitor and review errors in the end-to-end process, including escalation and investigation in line with all stock ordering and control issues identified within this report.	29/02/2024	1486.92		0.00		Completed/Closed	Completed/Closed	March 2024: Completed				31/03/2024
Internal	2024.01	Facilities - Jan 2024	Limited	Chief Operating Officer	Medium	R5.1	Management should review the security arrangements at each site and if appropriate to do so, add additional security measures where required.	ACCEPTED. The following steps will be taken to address the issue:Undertake a Privacy Impact Assessment in conjunction with Information Governance to assess the viability of CCTV cameras within stock areas	29/02/2024	1486.92		0.00		Completed/Closed	Completed/Closed	March 2024: Already Marked as completed in the internal audit report.				31/03/2024
Internal	2024.01	Facilities - Jan 2024	Limited	Chief Operating Officer	Medium	R5.3	Management should review the security arrangements at each site and if appropriate to do so, add additional security measures where required.	2 Ensure stock ordering, management and control processes easily identify stock anomalies and there is a robust process for investigation and escalation	01/03/2024	1486.95		0.00		Completed/Closed	Completed/Closed	March 2024: Completed				31/03/2024

Internal	2024.01	Facilities - Jan 2024	Limited	Chief Operating Officer	High	R6.2	Waste levels should be monitored and reported to the monthly Facilities meetings and any anomalies investigated.	Food waste to be presented to and monitored by the Head of Facilities, as part of monthly performance highlight report at Facilities Management Team meetings	31/03/2024	1487.93		0.00		Completed/Closed	Completed/Closed	March 2024: Reports discussed at FMT in March This will continue as 'business as usual'				31/03/2024
Internal	2024.01	Facilities - Jan 2024	Limited	Chief Operating Officer	Medium	R7.1	Management should investigate the following system improvements and implement if appropriate:Stock Management System • the functionality between Oracle and Synbiotix to create a functional and effective stock management system; and • the designation of preferred stock within Oracle, e.g. a particular brand of bread loaf and adding this to the ordering sheet that is sent to managers for approval, to assist with the selection of the lowest cost item.	explore the feasibility of using the stock control element of the Synbiotix system as it has the ability to record all goods received and track their usageand assess other stock management systems	29/02/2024	1486.92		0.00		Completed/Closed	Completed/Closed	March 2024: Meetings with Synbiotix have show that this is a feasable option. We are now assessing the requirements of the HB to implement the system and will be developing a cost/benefit analysis to support the decision making process				31/03/2024
Internal	2024.01	Facilities - Jan 2024	Limited	Chief Operating Officer	Medium	R7.2	Management should investigate the following system improvements and implement if appropriate:Stock Management System • the functionality between Oracle and Synbiotix to create a functional and effective stock management system; and • the designation of preferred stock within Oracle, e.g. a particular brand of bread loaf and adding this to the ordering sheet that is sent to managers for approval, to assist with the selection of the lowest cost item.	Ad-hoc audits of all items ordered via oracle on a monthly basis to ensure all sites are adhering to the approved stock items	29/02/2024	1486.92		0.00		Completed/Closed	Completed/Closed	March 2024: Already Marked as completed in the internal audit report.				31/03/2024
Internal	2024.01	Facilities - Jan 2024	Limited	Chief Operating Officer	Medium	R7.5	Management should investigate the following system improvements and implement if appropriate: Bank: • the possibility of using the AllocateMe function within the Bank Staff system to create a better approach to allocating bank shifts to a wider pool of staff; • utilisation of Safe Care or Allocate to monitor when staff start and end their shift; and • the completion of the programme of work to prevent staff from completing all associated steps of approving and paying a bank shift.	As part of the Health Roster payroll drop down project and pre enabling plan a review of all staff's access levels will be undertaken	29/02/2024	1486.92		0.00		Completed/Closed	Completed/Closed	March 2024: Already Marked as completed in the internal audit report.				31/03/2024
Internal	2024.01	Facilities - Jan 2024	Limited	Chief Operating Officer	Medium	R7.6	Management should investigate the following system improvements and implement if appropriate: Bank: • the possibility of using the AllocateMe function within the Bank Staff system to create a better approach to allocating bank shifts to a wider pool of staff; • utilisation of Safe Care or Allocate to monitor when staff start and end their shift; and • the completion of the programme of work to prevent staff from completing all associated steps of approving and paying a bank shift.	Managers to be responsible and accountable for reviewing and approving Health Rosters in line with Health Board policies. This will also include ensuring templates are accurate.	29/02/2024	1486.92		0.00		Completed/Closed	Completed/Closed	March 2024: Being monitored via FMT reporting and workforce performance reports				31/03/2024
Internal	2024.01	Facilities -	Limited	Chief Operating	Medium	R7.7	Management should investigate the following system improvements and implement if appropriate: Bank: • the possibility of using the AllocateMe function within the Bank Staff system to create a better approach to allocating bank shifts to a wider pool of staff;	All members of the management team to undergo formal Health Roster training	31/01/2024	1485.97		0.00		Completed/Closed	Completed/Closed	March 2024: All current members of the management team have completed the training and a session is scheduled for any incoming members of the team				31/03/2024

l	2024.01	Jan 2024	Limited	Operatin g Officer	Medium	R7.1	to a wider pool of staff; • utilisation of Safe Care or Allocate to monitor when staff start and end their shift; and • the completion of the programme of work to prevent staff from completing all associated steps of approving and paying a bank shift.	Roster training with Workforce and Organisational Development	31/03/2024	1485.97		0.00		Completed/Closed	Completed/Closed	training and a session is scheduled for any incoming members of the team				31/03/2024
Internal	2024.01	Facilities - Jan 2024	Limited	Chief Operating Officer	Medium	R8.1	Management should continue to monitor and inform staff of their responsibilities regarding bank shifts. Where individuals regularly do not comply with the Health Board's Resource Bank – Booking Rules this should be escalated and dealt with appropriately.	Continue to monitor Bank Shift Booking Reports and address issues in accordance with Health Board policy	31/03/2024	1487.93		0.00		Completed/Closed	Completed/Closed	March 2024: Process in place. This continued action is now 'business as usual'				31/03/2024
Internal	2024.01	Facilities - Jan 2024	Limited	Chief Operating Officer	Medium	R8.2	Management should continue to monitor and inform staff of their responsibilities regarding bank shifts. Where individuals regularly do not comply with the Health Board's Resource Bank – Booking Rules this should be escalated and dealt with appropriately.	Implement a process that ensures All non-compliance reported to Head of Facilities, who will ensure that each occurrence is reviewed by the responsible manager in line with Health Board Policies, with findings presented back to the Head of Facilities.	29/02/2024	1486.92		0.00		Completed/Closed	Completed/Closed	March 2024: Already Marked as completed in the internal audit report.				31/03/2024
Internal	2024.02	Estates Condition - Jan 2024	Limited	Director of Strategy, Planning & Partnerships	Low	R3	The Health Board should assess the sufficiency of reserve funds to address backlog at the handover of PFI buildings.	Agreed - The PFI agreements include a minimum level of expected condition for buildings &/or equipment to be maintained for operational capability. Regular management review ensures these contract terms are being met. When handover of PFI assets are expected escalated arrangements are put in place to assess the level of condition. The following PFI schemes exist: NHH LLanwenarth day surgery unit, which has now gone through a process of 'buy back' of the headlease. The operating lease will end in 2024, the process of negotiating a settlement figure has agreed the equipment and building condition expected at handover date. Chepstow Community Hospital PFI is in advanced discussions with the owner/provider relating to the PFI end in Feb 2025. Negotiations relate to the building being in a Condition B status at time of any handover, a condition review has been commissioned and the PFI provider has agreed to implement improvements to meet condition B. Energy PFI (Honeywell) in NHH which ends in December 2026. This PFI is about to undergo a readiness assessment through WG for PFI end but does not relate to buildings and only relates to plant. Monnow Vale – ends in March 2036	31/03/2024	1487.93		0.00		Completed/Closed	Completed/Closed	March 2024: "Both building PFI schemes are due to be finalised this financial year (Llanwenarth - June 2024 and Chepstow - February 2025) and the agreements mean that the buidings will be handed back in condition B. Llanwenarth agreement has been signed (March 2024) with Chepstow due in the coming months."			"Both building PFI schemes are due to be finalised this financial year (Llanwenarth - June 2024 and Chepstow - February 2025) and the agreements mean that the buidings will be handed back in condition B. Llanwenarth agreement has been signed (March 2024) with Chepstow due in the coming months."	31/03/2024
Internal	2024.02	Estates Condition - Jan 2024	Limited	Director of Strategy, Planning & Partnerships	High	R4.1	Management should review and implement effective reporting of Estates condition/ backlog across the UHB's Committee structure e.g. outcomes against targets, funding risks, risk exposure etc.	Agreed. The Board's Finance and Performance Committee has delegated responsibility to seek assurance that arrangements for the performance management of capital, estates and support services related standards and systems are sufficient, effective,and robust, including: • the monitoring of capital and estates related objectives and priorities as set out in the Board's IMTP and Annual Priorities; • the monitoring of compliance with Health Technical Memorandums; • the monitoring of progress in delivery Board-approved capital business cases and programmes of work. This is set out in the agreed Terms of Reference for the Committee. Work is ongoing to develop workplans for each Committee for the 2024/25 financial year and this will consider the role of each Committee and the work required to fulfil the respective Committee's obligations. In 2023/24, work was undertaken to revise the Capital and Capital Project governance arrangements which encompassedbacklog maintenance within the discretionary capital programme. These governance arrangements were reported to the Board's Partnerships, Population Health and Planning Committee in July 2023	31/03/2024	1487.93		0.00		Completed/Closed	Completed/Closed	"March 2024 - The three points below have been included in the F&P Forward Work Programme • the monitoring of capital and estates related objectives and priorities as set out in the Board's IMTP and Annual Priorities; • the monitoring of compliance with Health Technical Memorandums; • the monitoring of progress in delivery Board-approved capital business cases and programmes of work. The PPHP Committee has the following report on its FWP. • Update Report on Discretionary capital programme. "			FWPs are going through a strengthened governance process which will ensure they are informed by key stakeholders and audit recommendations.	31/03/2024
Internal	2024.04	Stakeholder Engagement on IT Projects	Substantial	Director of Digital	Low	R1	A template should be developed in order to record all workshop attendance	Standardised templates for Steering Groups and Workshops will be developed b the Buisness change Team and will be incoorporated into the Project Management Framework.	31/03/2024	1487.93		0.00		Completed/Closed	Completed/Closed	Mar 24 - Attendance sheet template developed and guidance on its use issued to project teams. Links to documentation included in Project Management Framework.			Completed - Attendance sheet template developed and guidance on its use issued to project teams. Links to documentation included in Project Management Framework.	31/03/2024

Internal	2024.04	Stakeholder Engagement on IT Projects	Substantial	Director of Digital	Low	R2	Consideration should be given for a single record to track attendance at project and programme boards.	A meeting attendance tracker will be created and will be implemented for use by all project boards.	31/03/2024	0.00		0.00		Completed/Closed	Completed/Closed		Mar 24 - Meeting attendance tracker template developed and guidance on its use issued to project teams. Links to documentation included in Project Management Framework.			Completed - Meeting attendance tracker template developed and guidance on its use issued to project teams. Links to documentation included in Project Management Framework.	31/03/2024

Appendix 7: Not Yet Due Recommendations

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Priority	Recommen-dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC Comittee	Final Report Deadline Status	Revised Deadline Status	If closed and not complete please	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close/complete the recommendation?	Reporting Date
Internal	2017.00	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies and Health Science	High	R2	R2 A clear robust control mechanism should be established by the divisions / directorates demonstrating the consideration and delivering of applicable training,aligned to medical equipment and devices. Training records should also be uploaded onto ESR.The poor mandatory training compliance rates with regard to infusion devices / pumps should be addressed as a matter of urgency.	From a Divisional perspective, the cascade training provided at ward level has not raised any particular safety issues, although with the increasing use of bank and agency staff, consideration should be given to accessible on site training for these members of staff. The Health Board to consider establishing a catalogue of equipment that needs specific training to operate, alongside a database of staff compliance.	31/03/2018		31/05/2024			Overdue	Not Yet Due		Nov 2022: An infusion device training strategy was presented to the April Medical Devices Committee. A training implementation plan is now under development to support the roll out of a more resilient process in line with the strategy. This aims to assure that training provision can match the need associated with both attaining and maintaining compliance levels at or above the standard. Unfortunately due to staff sickness absence, further development work has not been fully realised. • Recruitment to now vacant QPS Infusion Device Service Training Manager post is in progress. • An exercise has been started to consolidate the training records for infusion devices and provide a compliance dashboard. Piloting this will inform a plan to capture monitoring of training compliance for other groups of medical equipment.	January 2024: Ward and departmental managers need appropriate resources to engage in the identification and the making available of staff for training Obtaining a match with an appropriate level of quality for the Health Board's needs from the training that can be provided by the manufacturer needs scrutiny Lack of manufacturer personnel limiting ability to respond with support to run training sessions on a large scale	January 2024: The dominant risk factor related to this recommendation is that infusion therapy delivered by infusion device is unable to be provided if an insufficient number of trained staff are present on a given shift roster, this is assessed as a having a current risk exposure level of 9 (high). The following mitigation actions are identified: · Follow up on seeking responses to the infusion training questionnaire originally sent out to ward and departmental managers in January 2023 and update consolidated infusion training database accordingly - this would give assurance the organisation is running at an appropriate infusion training compliance level by providing an accurate denominating figure · Increase capacity for provision of infusion device training, including using manufacturer's training resource for revalidation training using a cascade training model This risk is currently being partially mitigated by providing ad hoc training sessions in a seminar room in OSU to ensure new starter training for end users is being delivered as able. Fresenius reps helping with staff updates as able prior to finishing in post. Cascade sessions delivered to paediatric nurses as able, to enable them to support with delivery of paeds updates.Need for fixed infusion device training base escalated and venue being sought.	New QPS Infusion Device Service Training Manager now in post.Consolidation of the infusion device training records aim to be achieved by end of Sept 23, Development of a dashboard to indicate compliance levels aim to be achieved by December 2023.Piloting migrating the infusion device training records to HealthRoster/ESR dependant on outside agencies.	
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R6	R6 Consideration should be given to the placement of all informatics provision and support across the Health Board. As part of this the current partially decentralised model should be re-assessed in terms of its suitability for the modern use of technology.	Accepted. Following the exec review of the Target Operating Framework and overarching governance will appraise the hybrid environment of departmental asset ownership, responsibility, risk management. As the report sets out this is a largely historical and organic model which will be complex to resolve in itself. A risk based approach will be adopted andan options paper will be developed forconsideration by the Board.	31/12/2022		31/05/2024		28.11.2023	Overdue	Not Yet Due		January 2024: The target operating model has been reviewed by the new Director of Digital and a proposal on the revised structure will be presented to the Executive Committee in April 2024. This structure will bring forward some options on the current decentralised model in some departments. Nov 23: The HIMSS maturity report has been excepted and it will be played into our Digital Strategy and IMTP planning. August 2023: The new Director of Digital is currently reviewing the TOF and will present findings and an action plan for the consideration by the Executive Committee in October 2023 November 2021 - This is pending the TOF being funded and requires a full risk assessment to be conducted once the business analysis has been completed.				
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R9	R9 A network of champions across the organisation should be established. The Digital Strategy should be re-issued alongside the roadmap. This should form the basis for engaging the network of champions to drive the Strategy forward.	Accepted-The Channel 3 report also identified a need for more emphasis on Clinical Leadership, Design and Business Partnering. This is subject to additional investment although recently the appointment of a full time CNIO/CSO has been a significant step forward. Outwith the Directorate recommendations will be presented to Execs on overarching exec level oversight which is intended to both strengthen accountability but also to ensure Informatics capacity is used to best effect. Benefits realisation training has commenced in Informatics and will form part of reporting. It is in principle agreed that the Health Board adopts a single methodology and framework that should be co produced to manage all priority investments.	30/09/2021		31/07/2024		08/02/2024	Overdue	Not Yet Due		January 2024: The Digital Champions network for Microsoft 365 has been relaunched and there are plans to further develop this through networking events and lunch and learns. Similar networks are being planned for Analytics and the refreshed Clinical Council. Nov 23: Progress has been made on the request process, business partnering and governance and will be completed by the 31/12/2023. The Digital Champions Network has recently been relaunched. Aug-23: New Digital Service Request process, business partnering and new governance group is under development May 2023 - A divisional engagement model has been agreed for managing new service request and work in progress activities. A CSS meeting has been established. Urgent care to be established next and roll out to follow as resources allow. March 2023 - Director of Digital has been appointed and a review of the Digital Delivery Oversight Board will take place once they are in post January 2023 - Funded CNIO and Nursing Informatics lead. First Divisional meeting scheduled for December and await the outcome of the financial bid for the TOF September 2022 - Informatics have fully funded the Nursing Informatics Post and an increase in allocation for clinical leadership. The TOF paper being submitted in October 22 addresses the immidiate priorities for more effective engagement with Informatics in the HB.				
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R13	R13 Critical assets should be identified within the asset and configuration management systems.	Agreed. This in part is due to the devolved nature of informatics.The first step will be presenting the new operating framework's overarching governance recommendations will provide oversight. A strategy, policy and resultant business case will be developed following the Health Board adoption of the reviews recommendations.	31/12/2021		30/06/2024		08/02/2024	Overdue	Not Yet Due		January 2024: New Cyber Security Assurance Group will be meeting in January 2024 and will provide assurance through the Information Governance Sub-Committee including progress against the NIS action plan which has now been developed. A component of this action plan is the identification of critical assets, further timelines will be developed after the first meeting of the Cyber Security Assurance Group. In addition, the Cyber Resilience Unit will be visiting the Health Board in late January to discuss progress against the Network & Information System Regulations. In April 2024 work will commence on the Health Board's new security platform which will provide visibility of all assets connected to the network which will improve the visibility of critical assets which may not be managed by the directorate. Nov 23: New Cyber Security Assurance Group will be meeting in January and will provide assurance through the Information Governance Sub-Committee including progress against the NIS action plan which has now been developed. A component of this action plan is the identification of critical assets, further timelines will be developed after the first meeting of the Cyber Security Assurance Group. Aug 2023: Awaiting next HBOTS meeting. May 2023 - work to commence shortly under SIRO March 2023 - Part of work programme that will be commencing from May under Rani				
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R14	R14 The asset and configuration management processes developed within the Informatics Directorate should be adopted as Health Board wide documents and departments with devolved control required to comply with the requirements.	Accepted. The HB governance, policy and processes will be reviewed as part of the SIROs objectives with resultant recommendations to Board. Informatics will need to review internal processes and capacity to ensure it can scale to meet the challenge.	31/12/2021		30/06/2025		08/02/2024	Overdue	Not Yet Due		January 2024: No progress, wider asset management approach and configuration management approach to be formalised during 2024/2025 financial year. Aug 2023: Awaiting next HBOTS meeting.				

Internal	2021.00	Mental Health & Learning Disabilities Divisional Review, June 2021	Reasonable	Chief Operating officer	Low	R3	R3 We recommend that the Flow Centre Team produce and monitor regular performance information over key risks within the process. For example, call waiting times.As this process is already underway, the Team should continue to identify other key performance indicators.This information should also link into individual performance within the Team, for training and improvement.	Agreed. We will:•clarify the audience and reporting requirements;•monitor performance information / KPIs on a regular basis;•identify the top five indicators;•develop a reporting dashboard;and•further refine performance reporting.	30/09/2021		31/01/2025		08/02/2024	Overdue	Not Yet Due		January 2024: Remains Outstanding. June 2023 - Remodelling of service and introduction of APP to FC so KPI to develop in line with new modelling	Quality of data and minimal guidance for reporting on performance	Fortnightly performance meetings, Divisional assurance meetings and triangulation with other governance processes.	ongoing	
Internal	2021.05	Pathology	Reasonable	Chief Operating Officer	Low	R8	R8 The Health Board should complete a refresh of the latest workforce planning exercise(including associated laboratory space and equipment), to ensure the service requirements can still be met over the next five years and beyond.Where additional resourcing / facilities arerequired, theseshould be factored into the IMTP process.	To review and updateworkforce plans as appropriate. Workforce is factored into the IMTP	24/02/2022		01/09/2026		08/02/2024	Overdue	Not Yet Due		January 2024: Workforce model to address Demand and Capacity gap for Cellular Pathology laboratory has been developed that will allow annual laboratory demand to repatriated from outsourcing from April 2024. Equipment requirements to support repatriation of outsourcing are identified and included in Divisional Capital request for 24/25. Plan in progress to reconfigure current accommodation in Pathology block in RGH to provide suitable medium term accommodation (ETA for accommodation plan 31/03/24). Wider Cell Path workforce plan to include Digital Cell Path future challenges to be developed (ETA end of 24/25). Microbiology WFP has been developed and continues to be reviewed and updated, with HR input, as the landscape regarding Health Protection Services (HPS [formally COVID]) develops. Current core, HPS and Hot lab WFP being reviewed to define impact to service if current funding streams are not recurrent. All managers were asked to review their workforce plans following the audit. The Cellular Pathology workforce plan is included in sustainability paper, JH has confirmed the paper will need to be re-reviewed if 7 day working is planned. Mortuary workforce plan in progress with follow up meeting 6 weeks from 27/9/22. Microbiology workforce plan in progress to be completed by 5/10/22. Blood Sciences workforce plan in progress to be reviewed 5/10/22 prior to completion. All	Time constraints: Accurate workforce planning takes a considerable time to complete. Managers need to manage staff and departments while ensuring other strategic and operational tasks are undertaken on a daily basis to ensure continuation of safe service delivery.	Agency staff being utilised at a cost. Overtime being utilsed at a cost. Scrutiny forms and SBARS submitted to request additional staff that are urgently required prior to implementation of revised workforce plans.	Workforce plans to be completed as soon as is possible Following completion, business cases may need to be produced and submitted for approval to recruit the additional staff required which will ensure Pathollogy service requirements will be met over the next five years and beyond.	
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R10	R10 The WRIS backups should be subject to regular testing / restore to ensurevalidity.	A request to ensure that a process for regular testing of the back up to ensure their validity will be made.	30/04/2022		30/04/2026		08/02/2024	Overdue	Not Yet Due		January 2024: Please refer to completed assurance report. Nov 2023: WRIS backups with recent upgrade work proved to be reliable.				
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R2	R2 The Health Board should seek clarity over why the requests made to DHCW and the SMB for an integrated electronic process cannot be delivered. The Health Board should carry out an analysis to fully identify its needs for a Radiology system and seek to include these within WRIS or any future system.	We have tried to seek clarity and not had a full response.Arequest for CWS to include WCP for radiology reporting in the platformhas been formally raised. We haveraised the need for end to end requesting as a health board to the collaborativeboard for RISP project.	31/03/2022		30/09/2024		08/02/2024	Overdue	Not Yet Due		January 2024: Please refer to completed assurance report. Aug 2023: The UAT has been passed and is with clincial apps and is being trialled in Primary Care on the 11/09/2023. There are discussion amonst informatics about integrating the WCP requesting within CWS and we have done early scoping exercises with a bussiness analysist revewing this currently. May 23: The UAT has been passed and is with clincial apps and Mr Rice to look at.	Aug 2023: Required scoping, testing and development and planned for software development Needs to be agreed locally and product developed to suit ABUHB			
Internal	2021.26	Facilities - Care After Death	Reasonable	Chief Operating Officer	Medium	R3	R3 The Care after Death Team should determine if the software delivers sufficient benefits in excess of the potential risks. If not, then alternative software / system should be procured, to include some / all of the following features: • remotely accessible across all sites, at all times; • update immediately following any change inputted; • link to key software within the Health Board, to minimise manual data entry; • produce management information / a dashboard and other relevant information (e.g. patient location); • raise warnings where breaches to the SOPs are imminent, e.g. capacity, temperature (if recommendation three is adopted) warnings; • a full audit trail including access information and data changes; • support profile levels to facilitate access control; and • be fully compliant with the Health Board and DHCW shared service software requirements	It is acknowledged that the current system does present the Health Board with a risk due to the issues as identified within the audit. The issue of the current & inherited database being unfit for purpose is acknowledged; the Estates & Facilities Divisionwill now engage with suppliers to identify a suitable replacement software system. A three-month window to identify supplier, design a system and implement is believed to be a significant challenge. It is expected that this work may take up to a six-month period.	31/03/2023		31/09/2024		08/02/2024	Overdue	Not Yet Due		January 2024: Partially completed. This risk has been resolved/removed by some minor changes to the current CAD database and development work that will make the body store details available in Qlik. Awaiting final verification of Qlik data. Estimated date of completion 31/03/24 November 2023 - new software was not procured due to cost implications. Work undertaken to cleanse databse and ensure that relevant fields are completed to enablel reports to be produced through Qlik. Work on reporting is currently underway. Update August 2023 - np new software procured by W&E. A meeting with informatics took place on 18/08 to discuss current database. Agreed Informatics do not have the expertise to make any significant changes to the system but have committed to maintain the system by best endeavours. Agreed that Qlik will be used to produce reports. Nov 2022 Alternative software solution has been procured via Synbiotix. Ongoing liaison between Synbiotix, IG & IT infrastructure teams to ensure all relevant safety aspects are mapped out. Further development work alongside Information Governance team to understand the barriers to uploading patient information is being undertaken.	IT Infrastructure Team resouce capacity may delay the implementation.	November 2023 - Meeting with IT and support has been put in place for basic maintence of database with reports being run through Qlik Mar 23 Ongoiong liaision with Associate Director of Informatics Strategy & Planning	Q4 of 2022/23	
Internal	2021.26	Facilities - Care After	Reasonable	Chief Operating	Low	R4	R4 The Care after Death Team should: • develop call cascade lists to identify staff contact details in advance; • identify additional scenarios that may arise and detail action plans to overcome them;	The CaD Team accept this recommendation in full	31/03/2023		31/09/2024		08/02/2024	Overdue	Not Yet Due		January 2024: Partially completed. BCP has been developed and fridge and freezer plans in place to manage winter pressure. Additional capacity has been implemented. Cascade lists still to be added to BCP by 31/01/24 November 2023 -fridge/freezer capactiy is still available on the database and space can be identified in the event of unavailabitliy. Work underway at RGH to install 56 further fridge/freezers (est completed December 2023). Deceased	28/07/23 Environment Act (Wales) increased recycling regulations to be enforced from Apr 24 (non-inpatient premises)		Q3 2022/23	

Internal	2021.20	Care After Death	Reasonable	Operating Officer	Low	R4	• test a range of continuity events regularly (at least once a year); and • identify fridge / freezer capacity plans that could be utilised in across different sites, in the event of unavailability.	The CAD Team accept this recommendation in full.	31/03/2023		31/03/2024		08/02/2024	Overdue	Not Yet Due		patient storage business contuity plan is currently being updated to identify/reflect new or additional scenarios. Update August 2023 - fridge/freezer capactiy available on the database and space can be identified in the event of unavailabitliy. Mar 23 Being developed by CAD Manager. 24/03/2023 CAD Team have been sited within CSS Division since November 2022. Due to temporarily return to E&F in April; Facilities Manager to work with team to completion during Q1 of 2023/24.	from Apr 24 (non-inpatient premises) and Oct 25 (inpatient premises). Requirements may change in the lead up to implementation of the Act		Q3 2022/23	
Internal	2022.12	Records Managment	Limited	Director of Digital	Medium	R4	R4 The management of ward clerks should be centralised, and consideration should be given to manage shortages through "bank arrangements".	a.) Local ward clerk shortages will be escalated to the Assistant Directors of Nursingand subsequently escalated to the Executive Director of Nursing. Action plan will be agreed how to solve them. b.) The clerical bank is undertaking a rolling programme of recruitment which will benefit the short notice requirements for ward clerks and this information will be disseminated by the nursing hierarchy to the ward staff.	31/07/2023		30/06/2024		08/02/2024	Overdue	Not Yet Due		Jan-24: First level of organisational process is underway and will commence in February. Nov 23: Will be discussed at Executive Committee and considered as part of the Digital Organisational Change Process				
Internal	2022.12	Records Managment	Limited	Director of Digital	Low	R9	R9 Loose patient records should be properly filed	The CNIO will reinforce this requirement with the ward staff. The process for creating DHR supplementary folders on wards will be shared with all Divisional nurses.	31/03/2023		30/06/2024		08/02/2024	Overdue	Not Yet Due		Jan-24: Ward visits undertaken by records management staff to ensure loose notes colelcted from sites. As a part of the Digital Strategy, a review will be undertaken for a review of digitisation of the remaining health records, with a key requirement being eForms. With reference to R4, we can pick up any further improvements to be made to loose patient record filing. Nov 23: The promotion of good practice continues and the roll out of WNCR at NHH has commenced. Aug-23: Health Records have found significant amounts of loose filing on wards in RGH & St Woolos. This has been collected and scanned but has a negative impact as each sheet needs to be individually checked, barcoded and scanned rather than as a complete record. The rollout of WNCR has reduced paper generation on wards and the CNIO has been promoting good practice on wards as the system rolls out across RGH. Further implementations at YYF and NHH will further reduce the loose records situation.	Further rollout of WNCR in YYF, YAB, NHH will reduce the loose records and guidance will be provided to the staff on the wards in these areas.	Training of ward clerks where there are issues identified is ongoing and datix reports submitted where substantial breaches are identified.		
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Low	R1	A formal SOP should be defined that sets out how the RPA process is to be managed. The operational service model should be fully defined and the terms of reference for the governance board reviewed and updated.	Upon successful investment case being made this will be addressed as part of the transisition to service delivery	01/06/2023		30/06/2024		08/02/2024	Overdue	Not Yet Due		Jan-24: RPA posts are in the Trac process for readvert and interview. A draft operational model has been developed. Completion remains dependent on successful team recruitment Nov 23: Unable to recruit necessary posts so investigating alternative options. Aug-23: 2 posts funded for a permanent team.Recruitment underway. Team will sit within Softwrae development as part of Integration services				
Internal	2022.18	Monitoring Action Plans	Reasonable	Director of Nursing	Low	R2	Management should review the number of actions raised within the HIW reports and the number of actions noted within the reports sent to committees for accuracy. Management should ensure no actions have been missed from the HIW report	The Health Board agrees with this recommendation. An update to the SOP will be developed to ensure a Quality Assurance check is undertaken, confirming that all actions have been captured and referenced	01/05/2023		30/04/2024		08/02/2024	Overdue	Not Yet Due		Januray 2024: In process of moving all inspections onto AMAT. The system will automatically generate reports, to include number of actions identified."This will be implemented across the HB in April 2024. August 2023: SOP updated to include the undertaking of Quality Assurance checks. In process of moving all inspections onto AMAT. The system will automatically generate reports, to include number of actions identified."				
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Medium	R2	We recommend that Health Board management ensure that formal discharge planning training is provided to both clinical and administrative staff engaged in the pathway, including updates if the process is amended.	The Health Board has a work programme for discharge to be overseen by the newly created Discharge Improvement Board, chaired by the Executive Director of Nursing. This will strategically co-ordinate the current workstreams and include oversight of the roll out of the 'optimising discharge framework' issued by the NHS delivery unit. All workstreams currently form part of the goals 5 & 6 for improving urgent care and this will now form part of the overarching discharge programme. Embedding the optimising discharge framework will be a key priority of the Discharge Improvement Board, with a launch event hosted by a number of Health Board Executives held in January 2023. Local training has already commenced with sessions delivered across the acute sites and with plans for roll out to the other hospital sites within the next 6 months. This will be supported by the national training programme to be delivered by the NHS delivery unit. The lack of procedural documentation will be addressed through the new discharge policy formation.	01/04/2024					Not yet due						

Internal	2022.19	Discharge Planning	Limited	Director of Nursing	High	R3	All patient discharges from the care of the Health Board are effectively controlled and evidenced by issuing a timely, completed discharge notification.	The Medical Director is aware that the timeliness of some discharge notifications needs to be improved. A letter was sent to all medical staff outlining their responsibilities in respect of timely discharge notifications in 2021. This is now being followed up by the Assistant Medical Director for Planning who will be leading a task & finish group to develop standardisation of approach. This work will aim to ensure that patients are able to leave hospital with their discharge summary / notification and ensure it will be sent electronically to the GP on the same day	01/04/2024					Not yet due							
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	High	R3	Where an expected, standard processes is assessed as not required, for example discharge meetings held to discuss needs and establishment of care packages, that the assessment and conclusion be evidenced.	The Health Board acknowledges that there is inconsistency in the documentation of MDT meetings. The introduction of the Welsh Nursing Care Record (WNCR) may provide an opportunity to capture the content of discharge meetings as a digital record which clinical and admin staff can access and will formally record the actions agreed. The Health Board's Chief Nurse for Information has been engaged in this process. In the interim, the Head of Discharge will work with ward staff to introduce a consistent approach to documentation and evidence in the notes. It should be acknowledged that discharge arrangements will vary considerably depending on the assessed requirements of the individual.	01/04/2024					Not yet due							
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	High	R3	A consistent discharge approach is adopted for all day care appointments and for inpatient transfers between Health Board sites	In respect of day care episodes of care, there are many diagnostic / treatment areas and specialities who have different methods of notifying both the GP and patient of the care episode. We acknowledge that this is not a standard approach with some departments combining the clinical details as the discharge summary. As part of the Task and Finish group, the Assistant Medical Director for planning will ensure that discharge notifications form part of the standardised approach. For inter-site transfers an SBAR is completed for every patient that outlines the patient's condition, diagnosis and any actions needed to be taken by the receiving site.	01/04/2024					Not yet due							
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Medium	R4	A method for identifying delays during the discharges of 'simple' cases should be introduced, monitored and reported	Discharge delays can affect both simple and complex discharges and therefore emphasis should be improving the process for all patients. Length of stay data is available to explore the feasibility and the benefits of such an approach. The Health Board continually seeks to identify the factors that delayed discharge and this work forms part of the workstream for goal 5 of the Welsh Government '6 Goals for Urgent and Emergency Care' programme. As part of this programme, the Delivery Unit has recently released the 'optimal patient flow framework', and the Health Board will be embedding these principles as 'business as usual'. The framework will also feature in the new All Wales Discharge Policy, to include the introduction of the SAFER principles, D2RA and 'red & green days'. These concepts have the potential to reduce LOS and improve discharge planning, so will be embedded within our policy.	01/04/2024					Not yet due							
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Medium	R5	Determining whether to make the use of the discharge checklist mandatory (including which aspects to include) or not and if so, the document should be consistently completed. Performance should be monitored until fully embedded.	Discharge checklists are used by most wards; however, we acknowledge there is an inconsistent approach in their use. The Welsh Nursing Care Record is currently being rolled out across the Health Board and may provide the opportunity to make the checklist part of the digital record as part of a standardised approach. In the interim, the use of checklists will be reviewed as part of the Discharge Improvement Board workstreams. The use of checklists will be further defined in the new discharge policy.	01/04/2024					Not yet due							
Internal	2022.19	Discharge	Limited	Director of	High	R6	We recommend that the Health Board ensure that the monitoring programme is reinstated and lessons learnt	The Health Board acknowledges that the monitoring as set out in the policy has not taken place. When drafting the new discharge policy we will consider the most appropriate audit mechanism to ensure that compliance is monitored	01/04/2024					Not yet due							

Internal	2022.19	Planning	Limited	Nursing	High	R0	from reviewing each service areas are shared throughout	and reported. The lessons learnt will be reported through the new Discharge Improvement Board and through to the 6 Six Goals Programme Board. Reporting will also be provided to the Executive Committee and PQSOC	01/04/2024				Not yet due							
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R7	The UHB should seek to obtain the necessary collateral warranties at the earliest opportunity.	Agreed, the necessary collateral warranties will be obtained at the earliest opportunity.	01/06/2023		28/02/2025		28.11.2023	Overdue	Not Yet Due		November 2023: there are numerous collateral warranties that occur at numerous points in the contract therefore this would not be completed until the end of the contract , i.e. February 2025. At this point in time the process for the provision of collectoral warranties has not required to be actioned as the relevant works have not be completed. Not currently at the point of issuing warranties. Aug 2023: At this point in time the process for the provision of collectoral warranties has not required to be actioned as the relevant works have not be completed. Not currently at the point of issuing warranties.	Aug 2023: None	N/A	Aug 2023: None, CWs have so far not been required	
Internal	2022.25	Integrated Wellbeing Networks	Reasonable	Director of Public Health	Medium	R2	Management should clearly identify what a successful IWN project is, and future projects undertaken by the local IWN communities (e.g. projects identified within the IWN annual plans) should state SMART goals whereby the success of the project can clearly be defined. Management should also identify what success of the IWN programme in each community looks like and once that target is achieved be able to move to other areas of need and implement the programme within those locations	An independent advisory group of academics has been created due to meet in July 2023 to advise on (a) measures of evaluating progress towards the strategic objectives of the IWN programme in each place-based area of operation and (b) longitudinal methods for measuring community wellbeing in an evidence-based manner to understand how and whether the IWN programme is impacting on population wellbeing in its place-based areas. It is anticipated by September 2023 that a new evaluation framework will be proposed by this advisory group, with funding now apportioned for the appointment of a commissioned researcher to undertake an evaluation and embed this framework in programme monitoring for IWN into the longer-term. This will set the direction of success for local IWN projects, allow SMART goal planning and measure the success of the programme to enable exploration of working in other geographic areas in future. The evaluation work will be complete by 31st October 2023. The programme is planning to apply the King's Fund model for community-orientated	01/10/2023		31/03/2025		08/02/2024	Overdue	Not Yet Due		The IWN service was due to be evaluated by a process to consider the efficacy and impacy of all RIF funded programmes, due to conflicting priorities this has not taken place. We are therefore undertaking an internal evaluation to review the work of the IWNs to date and also undertaking a mapping exercise to see what resource exists at a community intervention level and there impacts. This also needs to be considered in the policy context of the new social prescribing fraemwork which will also inform delivery of community level interventions.	A larger piece of work is needed due to the new policy context.	The scoping of this work will be complete by end of March 2024 with a new service model designed and ready to be implemented by March 2025		
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Medium	R1	Formal deadlines should be set by the Health Board to ensure the timely delivery of actions to maintain compliance with the Standards. Performance against these deadlines should be monitored and reported on.	The Standards have been developed and published by Improvement Cymru. There are no National Deadlines set for the Standards. This is continuously evolving and will help all Health Boards/regions to influence, shape and improve dementia care over coming years. These are the first 20 Standards and we anticipate that new standards will be introduced by Improvement Cymru over the coming years. We have updated the Board and Quality Patient Safety and Outcomes Committee of work undertaken during the readiness year. The Regional Dementia Board consider all the standards which are part of the dementia action plan, and this is also fed back to the Regional Partnership Board. The newly appointed Dementia Programme Manager will oversee all workstreams and, alongside reporting progress, we will report by exception any issues relating to implementing the Standards. Should Improvement Cymru produce deadlines, we shall revisit this recommendation. Additionally, once KPIs have been developed over the next 12 months, we will consider how we can best set	01/07/2024					Not yet due							
Internal	2022.28	Mental Health Transformation	Reasonable	Chief Operating Officer	Medium	R1	The control and oversight of each individual mental health transformation project is formally allocated, documented and communicated to all interested parties to the project. This should include any third-party bodies engaged and ensure that any duplication or omission of effort is identified and addressed. There is a need to ensure that assurance mechanisms, including those provided by third-parties can be relied upon. b. Any such document should ensure that key aspects of a project's development and implementation are considered including time, cost, benefits, linkage of projects to strategic objectives, management of risk and ongoing monitoring of targets etc.	A review of the control and oversight of each of the individual mental health transformation projects will be undertaken to ensure it is appropriately allocated, documented and communicated to relevant stakeholders. The document will cover the areas outlined in recommendation 1.1b	01/10/2023		30/04/2024		08/02/2024	Overdue	Not Yet Due		Januray 2024: A strategic review of mental health & LD services is being undertaken in tandem with a corporate led review of Divisional governance arrangements, with an initial strategic workshop being held on 12 January 2024. This will result in review of work programmes and projects and ensure that projects are aligned to delivery of agreed strategic priorities and managed in accordance with revised and agreed governance arrangements.				
Internal	2022.28	Mental Health Transformation	Reasonable	Chief Operating Officer	Medium	R1	The Whole Person Whole System Crisis Support Programme Board and the Mental Health Transformation Board established to provide oversight have Chairs appointed who are independent of divisional management to demonstrate and deliver the independence required of such bodies.	A review will be undertaken regarding the Chairs of both the WPWS Crisis Support Programme Board and Mental Health and Learning Disability Transformation Board.	01/09/2023		30/04/2024		08/02/2024	Overdue	Not Yet Due		**January 2024: A strategic review of mental health & LD services is being undertaken in tandem with a corporate led review of Divisional governance arrangements, with an initial strategic workshop being held on 12 January 2024. This will result in review of work programmes and projects and ensure that projects are aligned to delivery of agreed strategic priorities and managed in accordance with revised and agreed governance arrangements. Nov 2023.** Dr Kathryn Walters (Joint Head of Psychology, Counselling and Arts Therapies) has replaced the Divisional Director as the Chair of the Whole Person Whole System Crisis Support Programme Board. A more detailed update on progress will be provided in the next reporting cycle.				

Internal	2022.28	Mental Health Transformation	Reasonable	Chief Operating Officer	Medium	R1	The Whole Person Whole System Crisis Support Programme Board performs deep dives into projects to further scrutinise the information received in the Project Flash Reports.	Within the current structure of the Whole Person Whole System Crisis Support Programme Board there is currently the ability to focus on details regarding specific projects. However, a more formal approach to "deep dives" for individual projects will be introduced (12 monthly minimum) that will include comprehensive performance and benefits reporting.	01/09/2023		30/04/2024		08/02/2024	Overdue	Not Yet Due		January 2024: A strategic review of mental health & LD services is being undertaken in tandem with a corporate led review of Divisional governance arrangements, with an initial strategic workshop being held on 12 January 2024. This will result in review of work programmes and projects and ensure that projects are aligned to delivery of agreed strategic priorities and managed in accordance with revised and agreed governance arrangements. November 2023: The Board has agreed to carry out annual Board Planning and Development sessions where 'deep dives' will inform the onward planning for content. Dates in consideration for Jan/Feb 2024 being agreed at Nov 2023 Board	• Funding & locations of physical space to carry out sessions • Access to information with BAU teams for Operational Workstreams such as MH111p2 • Developments in systems to support in outcomes evidencing; eg Alt to inpatients theme. o Electronic PREMS/PREMS Programme have set up and manage collection of information. That information evidences qualitative & quantitative content for the services in the theme. The baseline comparators for BAU traditional services are not implemented electronically(EG Ward PROMS/PREMS) o The performance team priority has a request for virtual wards outstanding (2021) their focus has been with wider WCCIS issues.	• Funding - Looking at avaibility rooms in wider HB estate & in discussion with partner stakeholders to ID any cost effective/neutral space in they may be able to offer as co hosts • Access to information from BAU leads (MH111p2) – SRO to meet with GM & AGM to discuss information requirements for Programme for benefits realization & whole system impact for all stakeholders. • Systems – o Programme Manager is able to support wards in 'spread & scale' to support them(on request from servcie leads) in implementing electronic PROMS/PREMS issue and reporting. o Performance team recognise the priority requirement for virtual wards set up, and requesting it is reprioritised.	Ongoing anticpating closure evidence Feb 2024	
Internal	2022.28	Mental Health Transformation	Reasonable	Chief Operating Officer	Medium	R1	Consideration be given to the Whole Person Whole System Crisis Support Programme Board only receiving the Project Flash Reports and for this Board to then report by exception to the Mental Health Transformation Board on matters detailed in the reports	The Mental Health and Learning Disability Transformation Programmes (Whole Person Whole System Crisis Support Programme and Complex Needs Programme) will receive the Project Flash reports for all workstreams and those Boards will then report by exception to the Mental Health and Learning Disabilities Transformation Board.	01/09/2023		30/04/2024		08/02/2024	Overdue	Not Yet Due		January 2024: A strategic review of mental health & LD services is being undertaken in tandem with a corporate led review of Divisional governance arrangements, with an initial strategic workshop being held on 12 January 2024. This will result in review of work programmes and projects and ensure that projects are aligned to delivery of agreed strategic priorities and managed in accordance with revised and agreed governance arrangements.				
Internal	2023.03	Clinical Coding; Final Internal Audit Report	Reasonable	Director of Digital	High	R4.1	we reccommend that the Health Board devise a plan to address the longstanding underperformance in the monthly coding of episodes. The performance of the plan should be reported regularly to the Board or an appropriate forum.	The Executive Committee approved the restructing of the Clinical Coding department in August 2023, the agreed restructure when comlete wil deliver on the monthly coding of episodes target.	30/06/2024					Not Yet Due			Jan 2024: The Executive Committee approved the restructuring of the Clinical Coding Department in August 2023, the agreed restructure when complete will deliver on the monthly coding of episodes target.All posts have been approved by the vacancy scrutiny panel, they have been advertised on NHS Jobs and shortlisting / interview processes are completed. Some of the posts are being readvertised due to a lack of suitability of candidates.				
Internal	2023.03	Clinical Coding; Final Internal Audit Report	Reasonable	Director of Digital	High	R4.2	We reccommend that the Health Board devise a plan to address the longstanding underperformance in claering the backlog of uncoded episodes. The performance of the plan should be reported regularly to the Board or an appropiriate forum.	Backlog of episodes will be systematically coded when the new Clincial Coding Structure in implemented. The new structure provides the workforce with he capability to deliver on the monthly coded episodes target and address backlog.	30/06/2024					Not Yet Due			Jan 2024: Backlog of episodes will be systematically coded when the new Clincial Coding Structure is implemented. The new structure provides the workforce with the capability to deliver on the monthly coded episodes target and address backlog.Requires recruitment to new structure as above				
External	2018.01 EA	Structured Assessment 2018	Not Rated	Director of Digital	High	R3	R3 The Health Board should improve its information governance arrangements by: improving compliance with the information governance training programme to reach the national rate of 95%.	Information Governance training reviewed to include the legislation changes as a result of GDPR. An additional module was developed and launched for Cyber Security which is mandatory for all staff to complete. The Information Governance Unit has set up Information Governance Delivery Groups (IGDG) for each of the Divisions in the organisation. The meetings are held bimonthly and training is included on the agenda for every meeting. Discussions are held specifically around compliance and Managers are tasked with improving their compliance rates. Reports are assessed at Transformation to Digital (T2D) Delivery Board.	01/03/2020		30/06/2025		08/02/2024	Overdue	Not Yet Due		January 2024: Training compliance is currently 83%. The additional national Cyber Security modules added to the Information Governance training has hindered progress in improving compliance due to the time required to complete the training package. There is particularly low compliance amongst Clinicians and the Data Protection Officer has discussed this with the Medical Director. He will be reminding them of their responsibilities to complete the mandatory training. Mandatory training compliance we will report to the Information Governance Sub-Committee and further plans will be put in place to improve compliance to the 95% target. Audit sent out to ward managers and divisional senior nurses to determine current training compliance throughout ABUHB.	Identified as outstanding in Structured Assessment 2022 - The pandemic has hindered progress	Non compliance reports are being sent to senior managers within Divisions to ensure that compliance is monitored and actioned in these areas. Where non-comnplance persists targeted escalation routes have been established and the appropriate corrective action will be taken. Promotion of the audio learning tool for staff groups that have dificulty in leaving the workplace or access to computer systems and e-learning will be facilitated by the IG team and attendance recorded.	
External	2021.01	Audit of Accounts Report, 2020-21 –	Not Rated	Director of	Medium	R3	The HealthBoard should consider strengthening their IT Controlsas 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	i.With regards to our Windows Server 2008 environment, we have an active programme of work to either upgrade or decommission these servers. It is envisaged that by the end of the current quarter only a few servers may remain, although weare currently investigating options for these.ii.ABUHB have made significant progress in removing Win7/8.1 from our estate and currently have 0.4% to complete.There is an active programme of work to remove these devices from the network or upgrade them toa supported	31/12/2021		30/06/2025		08/02/2024	Overdue	Not Yet Due		January 2024: The work to remove legacy versions of Windows Server and Windows Desktop operating systems has gone well with no Windows 2008 servers remaining. No further action is required on change management had a robust process is in place with strong engagement with stakeholders and assessments for clinical safety. Further work is required to assess Backup and Recovery Policy and Starters, Leavers and Movers and will be part of the directorates workplan over the next two quarters. Nov 23: Critical Server refresh ongoing, KPI's being developed for presentation at Cyber Security Assurance Group Aug-23: No				

External	EA	Addendum issued December 2021	Not Rated	Digital	Medium	R3	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, leavers and accesses changes should beformally recorded, and the Health Board shoulddevelop a suite of audit and security reports to run and monitor to ensure user access is appropriate.	version of Win10.iii.We have an established and robust Change Management Process in place with regularly scheduled and structured Change Advisory Board meetings to manage operational change.The process has been widely socialised with all of Informatics and other Key Stake Holders, and also engages effectively with other ITIL practices such as Incident Management and Asset/Configuration Management.Critical Success Factors and Key Performance Indicators are agreed and monitored to measure effectiveness.iv.The IT Data Recovery Plan and Backup Policy is still in the	31/12/2021		30/06/2023		08/02/2024	Overdue	Not Yet Due		update - older servers are being replaced via Critical Server Refresh project, updated figures to be provided by SC May 23: No further update Mar-23: Discussion with 3rd party is still ongoing Jan-23 i. Currently there are 2 remaining servers left on 2008. These rely on upgrades to the software applications to enable the move to a supported Windows Server version. The team will continue to liaise with the services to remove the last 2 remaining. ii. Currently we have 3 devices remaining. The team will continue to liaise with the services to remove the last remaining. iii. Confirmed this was completed.				
Internal	2024.01	Facilities - Jan 2024	Limited	Chief Operating Officer	Medium	R7.3	Management should investigate the following system improvements and implement if appropriate: Bank: • the possibility of using the AllocateMe function within the Bank Staff system to create a better approach to allocating bank shifts to a wider pool of staff; • utilisation of Safe Care or Allocate to monitor when staff start and end their shift; and • the completion of the programme of work to prevent staff from completing all associated steps of approving and paying a bank shift.	The division will be rolling out the AllocateMe function as part of the Health Roster payroll drop down project. (The Health Roster payroll drop down project is forecasted to take twelve months)	31/01/2025						Not Yet Due							
Internal	2024.02	Estates Condition - Jan 2024	Limited	Director of Strategy, Planning & Partnerships	High	R1	Management should initiate discussion with NWSSP: Specialist Estates Services prior to the next submission of the EFPMS to confirm methodologies for assessment and measurement.	Agreed – the Divisional Director will ensure links with NWSSP prior to any submission of EFPMS data. The timing of this action will be subject to confirmed plans and timelines set by NWSSP for submission although at this point in time, the July 2024 date seems realistic.	31/07/2024						Not Yet Due							
Internal	2024.02	Estates Condition - Jan 2024	Limited	Director of Strategy, Planning & Partnerships	High	R2.1	Appropriate surveys should be undertaken following dialogue with NWSSP: SES.	Agreed – the Divisional Director has, since the fieldwork for this audit, been involve in two national level conversations with NWSSP about the future of facet surveys and how they should be done. There is no formal funding for regular surveys and these discussions are ongoing relating to most effective and cost effective solutions with WG and NWSSP across NHS Wales and will dictate the final implementation of this action	31/08/2024						Not Yet Due							
Internal	2024.02	Estates Condition - Jan 2024	Limited	Director of Strategy, Planning & Partnerships	High	R2.2	Planned disposals approved by the Trust Board should be removed from backlog data in accordance with guidance.	Agreed – guidance will be followed.This will be actioned for any future submissions for EFPMS and thus timeline will mirror that of MA 1.	31/07/2024						Not Yet Due							
Internal	2024.02	Estates Condition - Jan 2024	Limited	Director of Strategy, Planning & Partnerships	High	R5	The adequacy of the existing Capital Development & Estates workforce will be affirmed (in terms of capacity and associated skill sets required) and to inform a financial model for required revenuesupport.	Agreed - the Divisional Director will review the operational workforce required to manage the current level of reactive work and also to ensure compliance with the appropriate level of Planned and Preventative Maintenance (PPM).	31/05/2024						Not Yet Due							

Internal	2024.03	Intergrated Performance Dashboard Data Quality	Substantial	Director of Digital	Low	R1	We recommend that the Health Board develops a procedure document covering the steps to compile the Integrated Performance Report dashboard for Executive Management Team, committees and the Public Board Meeting.	With the development of the new electronic Integrated Performance Dashboard now being complete, a standard operating procedure for updating the dashboard to reflect reported performance will be developed.	30/09/2024					Not Yet Due						

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	16 April 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Update on Single Quotation and Tender Actions –20th January 2024 to 22nd March 2024**
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	**Director of Finance, Procurement and Value Based HealthCare**
SWYDDOG ADRODD: **REPORTING OFFICER:**	**Katy Jones – Deputy Head of Procurement**

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

This report provides the 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 20th January 2024 to 22nd March 2024

Cefndir / Background

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 Deputy Head of Procurement will provide a summary for each Audit, Risk and Assurance Committee detailing all actions submitted for

consideration. The Audit, Risk and Assurance Committee's work plan includes a standing item for review of the following at each meeting:

- Review of Single Quotation and Tender Requests.

Asesiad / Assessment

The Audit, Risk and Assurance Committee should note the detail of the attached table (Appendix A) and should monitor the number and value of business 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 10 requests submitted which have been approved during the period with an annual value of £1,443,455.79 Ex VAT.

Of these 6 approved requests were classified as services with 4 approved as goods type arrangements.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to note the content of this report for assurance.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. FInance Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives	Choose an item. Choose an item. Choose an item. Choose an item.

Strategic Equality Objectives 2020-24	

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.

Appendix A - Summary of Single Tender/Quotation Actions				
Date of Request	Type of Request	Reference No	Description	Anticipated Annual Value (ex VAT)
02.01.2024	Single Tender Action	ABU-STA-55267	Mobile Decontamination Unit - Temporary unit Extension on ABU-STA-53111	£57 645,65
16.01.2024	Single Tender Action	ABU-STA-55354	Security	£865 833,34
29.01.2024	Single Tender Action	ABU-STA-55461	Bespoke Cot Bed / Safe Space for Child LP	£6 817,50
30.01.2024	Single Tender Action	ABU-STA-55473	Bespoke Cot Bed / Safe Space for Child ES	£7 174,63
05.02.2024	Single Tender Action	ABU-STA-55474	Nurses Accommodation.	£144 060,00
15.02.2024	Single Tender Action	ABU-STA-55605	Domestic violence and abuse (DVA) training, support and referral programme - NCN Primary/Community	£196 158,00
28.02.2024	Single Tender Action	ABU-STA-Q28983	Fibroscan Mini Machine for YYF Outpatients	£94 500,00
27.02.2024	Single Tender Action	ABU-STA-55786	Gritting North Gwent	£40 000,00
06.02.2024	Single Quotation Action	ABU-SQA-53944	Educational update for GP Practices CPD	£17 791,67
23.02.2024	Single Quotation Action	ABU-SQA-53945	International Nurses Accomodation	£13 475,00

Supplier	Type
Getinge Ltd	Goods
HSG Facilities Management	Service
HKD Solutions Ltd	Goods
Safespaces (Cornholme) Ltd.	Goods
Campus Living Villages	Service
IRISi / Llamau	Services
Echosens	Goods
MRI Whistance	Services
NB Medical	Services
Tŷ SA – Serviced Accommodation Specialists	Services

Reason for request
A temporary mobile fully kitted out unit to maintain service of endoscopy decontamination whilst new centralised unit is built within the old Endoscopy area Level 3 RGH. A Business case is in place to build a new DECON unit but as of Jan 2024, BJC still not approved so an extension of 6 months to existing mobile unit needed as build on new De Con unit is estimated at 37 weeks - March 2025
Over the last 5 years, ABUHB have developed a good working relationship with HSG Facilities Management. They have delivered against fluctuating needs and have become an entrusted supplier to the health board. All Wales Security Service Framework rate exceeds the current HSG Facilities Management rate by £2.15 per hour
One off purchase for a specialist paediatric bed / safe space solution for a patient in the community. The spec of the URZONE solution has been developed with Occupational Health with the child's needs and requirements. The child has a number of complex health needs.
This is a one off purchase for a specialist paediatric safe space for a patient and is required as soon as possible. The spec of the SafeSpace solution has been developed with Occupational Therapy to help with the child's
The Health Board have approved the recruitment of 75 internationally educated nurses per annum for 2024 and 2025. Accommodation is limited across the South East Wales and is evidenced by a failed tendering exercise the was undertaken in January 2024, with the only bidder did not qualify. The Campus Living Village in Newport is the most cost-effective available accommodation in the area for the numbers due to join the
IRIS and Llamau are partners within Gwent for the delivery of the GP referral scheme. IRIS is a domestic violence and abuse (DVA) training, support and referral programme for general practices that has been evaluated in a randomised controlled trial. Llamau are a recognised local provider of the related services. IRIS is an evidence based intervention that is being delivered across a number of health boards – there is no recognised alternative provider
Echosens are the only suppliers of the portable mini. To purchase from another supplier would mean purchasing a very large ultra sound scanner which is not a portable device. Th HB currently have 5 across the HB so this will provide continuity of training and use.
Extension until April 2024 All documents are ready to go out to market in April 24. Extension for current gritting & snow clearing for MRI Whistance. Areas they cover is YAB, YTC, NHH, NRC, Ebbw Vale Clinic, and they also currently store bulk lose gritting salt 52 tons for gritting roads and foot paths, plus 20 pallets x 40 bags x 25kg per bag of gritting salt for grit bins
One off training to be held on 27th January 2024 for 240 delegates. Funding has been allocated from HEIW and the HB will claim back the full cost from HEIW. This supplier is not in any current frameworks but will deliver a package of multi┐ professional CPD over 1 day for up to 240 primary and community care clinical staff.
To support the arrival of 16 international recruits in cohort one arriving on 4th April 2024 and departing from the accommodation on 9th May 2024. (14 nurses and 2 doctors). Accommodation is limited across Wales.

Advice from Procurement
Gettinge awarded overall contract of new decon unit and this unit will contain a lot of new equipment while unit being built
As this work is continuing with a supplier that has already carried out previous role and this was awarded from a open competition this is approved up to a new tender going out to market.
Approved as this is genuingly the only suitable provider of the equipment
Approved as this is genuingly the only suitable provider of the equipment. A procurement exercise is being undertaken to cover specialist beds in the near future
The STA is endorsed on this occasion following a failed tendering exercise undertaken in January 2024, then only bidder did not qualify. An VEAT notice138868 has been published on the 12/02/2024.
A report was prepared on 28/02/2024 and the STA was approved
Echosens are the only suppliers of the portable mini Fibroscan in UK. Currently Supplier not on a Framework. Approved due to genuine one supplier and to ensure continuity with existing equipment
A tender is in the process of being drafted and competed to ensure future governance and move away from the previous STA approach.
Approved due to only one supplier who can offer this while also compatabilty to offer specific weekend availability
The SQA is endorsed on this occasion following an unsuccessful tendering exercise undertaken in January 2024, as the only bidder did not qualify.

Approved / Rejected	CEO Approval Date	Chairs Approval Date (If Applicable)
Approved	22.01.2024	
Approved	31.01.2024	
Approved	05.02.2024	
Approved	05.02.2024	
Approved	07.03.2024	
Approved	28.02.2024	
Approved	26.01.2024	
Approved	29.02.2024	
Approved	26.01.2024	
Approved	22.02.2024	

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	16 April 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Financial governance, reporting & control.**
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	**Robert Holcombe, Director of Finance, Procurement and Value Based HealthCare**
SWYDDOG ADRODD: **REPORTING OFFICER:**	**Mark Ross, Assistant Finance Director**

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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.
- Annual Accounts timetable
- Technical accounting issues.
- Public Sector Payment Policy compliance.
- Payments Exceeding £100K.
- Standing Financial Instructions

The Audit, Risk and Assurance Committee is requested to:

- Note the contents of this report.

- Approve the updated financial control policy and procedures.

    - Accounts Receivable (Appendix 1)
    - Counter Fraud Communication Strategy (Appendix 2)
    - Contract Management (Appendix 3)

Cefndir / Background

Financial control procedures are reviewed, as a minimum, on a 3 yearly basis.

The FCPs presented will be considered by the Executive Committee at their meeting on the 4th April and are presented to the Audit, Risk and Assurance Committee for approval subject to Executive Committee approval at that meeting.

A table has also been included to provide an update of the status of all financial control procedures.

Asesiad / Assessment

1.Financial Control Procedures (FCP)

The FCPs to be reviewed at this Committee as part of the regular programme of updates are:

- Accounts Receivable (Appendix 1)
- Counter Fraud Communication Strategy (Appendix 2)
- Contract Management (Appendix 3)

A summary of the main changes to each of the Financial Control policy/procedure is set out below. The full revised FCPs are included in Appendix 1 - 3.

1. Accounts Receivable

Owner: Director of Finance, Procurement and Value
Review Date: February 2024

The procedure sets out the requirements to ensure there are adequate controls in place to identify all sources of income, due to the Health Board.

Once income is identified, a control framework is to be followed, to ensure all income due is invoiced, collected, and accounted for correctly.

The document has been circulated for comment as follows:

- Assistant Head of Financial Services
- Head of Financial Services and Accounting
- Assistant Director of Workforce (Workforce & Organisational Development)
- NWSSP – Payroll Services

- NWSSP - Audit and Assurance Services

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
6.8, 7.1, 7.1.15	Process change – reference to the NWSSP – Payroll Services introduction of an Overpayments Platform in order to monitor, communicate and report overpayments of salary to employees
7	Procedure update – reference added in relation to the All-Wales NWSSP Overpayments Procedure which is currently being developed
7.4.2.2	Guidance update – Welsh Government arbitration guidance updated from 'Welsh Health Circular 2019_014' to 'Welsh Health Circular 2022_013'
7.4.2.6	Process update – reference to the requirement to report Overseas Visitors debt status, on a monthly basis, to the Department of Health & Social Care

2. Counter Fraud Communication Strategy

Owner: Director of Finance, Procurement and Value
Review Date: March 2024

The Counter Fraud Communication Strategy has been established to promote and raise awareness of the NHS counter fraud initiative.

The Local Counter Fraud Specialist (LCFS) is committed to ensuring that effective communication is undertaken to deter fraud and prevent the organisation from falling victim to fraudulent practices.

The document has been circulated for comment as follows:

- Head of Communications
- Director of Corporate Governance
- NWSSP - Audit and Assurance Services

Main changes to the document

Paragraph	Summary of change
All	Organisational change - Director of Finance changed to Director of Finance, Procurement and Value.
All	Organisational change – Board Secretary changed to Assistant Director of Communications and Engagement

All	Organisational Change – Audit Committee changed to Audit, Risk and Assurance Committee
All	Intranet links added for internal documents/external websites
5.1	Contact Points – Local Counter Fraud phone number and email updated
5.2	Contact Points – NHS Fraud and Corruption Reporting phone number and online link updated
5.3	Contact Points – NHS Counter Fraud Authority Media Team email updated

3. Contract Management

Owner: Director of Finance, Procurement and Value
Review Date: New procedure.

The procedure outlines the roles and responsibilities for managing contracts, with the use of standard templates, throughout the life cycle of the contract to ensure proactive contract management takes place.

It is recommended that all contracts with a total value greater than £100,000 are included under the procedure, as well as any lower value strategic/business critical contracts that would benefit from proactive management.

The procedure has been created from an Internal Audit recommendation to implement a standard contract management approach and understanding across all divisions.

A training and awareness programme, headed by Procurement, will run alongside this document.

The document has been circulated for comment as follows:

- General Managers across
  - Primary Care
  - Clinical Support Services
  - Medicine
  - Scheduled Care
  - Mental Health & Learning Disabilities
  - Urgent Care
  - Digital
  - Families & Therapies
  - Estates & Facilities
- Head of Financial Services and Accounting
- Assistant Finance Director (Hospital & Corporate)
- NWSSP - Audit and Assurance Services

The table below provides an update regarding the review dates for all of the Financial Control Procedures.

FCP	Year Due	Approved	Committee Approved	Review Date	Notes
Accounts Receivable	23/24	Due for review	Feb-21	04-Feb-24	Scheduled for Apr 24
Approval of Orders over £100K	23/24	Due for review	Feb-21	04-Feb-24	On hold until SoD Approved
Counter Fraud Communication Strategy	23/24	Due for review	Mar-21	12-Mar-24	Scheduled for Apr 24
Contract Management	New	New	New	New	Scheduled for Apr 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	
Counter Fraud Bribery and Corruption Policy	25/26	Y	Oct-22	25-Nov-25	
Capital Assets and Charges	25/26	Y	Dec-22	01-Dec-25	
Engaging Off Payroll Workers	25/26	Y	Feb-23	02-Feb-26	
Accounts Payable	25/26	Y	Feb-23	02-Feb-26	
Patients' Property	25/26	Y	Feb-23	02-Feb-26	
Purchasing Cards	25/26	Y	Feb-23	02-Feb-26	
General Ledger	26/27	Y	Apr-23	18-Apr-26	
Policy and Governance approach for Commissioning Additional (External & Insourced) Non NHS Clinical Services	26/27	Y	Apr-23	18-Apr-26	
Procurement Policy	26/27	Y	Sep-23	12-Sep-26	
Capital Procedures and Guidance Notes	26/27	Y	Nov-23	28-Nov-26	
Patients' Travel Costs Policy	26/27	Y	Nov-23	28-Nov-26	
Cash and Bank	26/27	Y	Nov-23	28-Nov-26	
Petty Cash	26/27	Y	Feb-24	08-Feb-27	
Petty Cash - Mental Health	26/27	Y	Feb-24	08-Feb-27	

2. Annual Accounts Timetable

Key Dates for Annual Accounts 2023/24

The Health Board have now received the confirmed dates for the submission of the draft and audited 2023/24 annual accounts. These along with other key dates are shown in the table below.

It is planned to take the final accounts for approval to the scheduled Board meeting on the 11th of July.

Annual Reports 2023/24 - Key Dates	**2024**	
First draft Performance Report and Accountability Report for consideration by Exec Team	Thurs	27-Apr
Unaudited accounts and associated returns to WG	Fri	03-May noon
Draft Performance Report Overview, Accountability Report and Remuneration Report to WG	Fri	10-May
Audit, Risk and Assurance Committee meeting to Consider Draft Accounts and Draft Accountability Report	Tues	21-May
Final Accounts & Accountability Report to Audit, Risk and Assurance Committee		04-July **Exact date TBC**

Audit, Risk and Assurance Committee meeting to Consider Final Accounts, and Accountability Report	Tues	09-July
Board meeting to approve Final Accounts and Accountability Report	Thurs	11-July
Final Annual Report Deadline for Submission to WG – Annual Report and Accounts as a single unified document	Mon	15 July noon
Annual General Meeting – to receive the Annual Report and Accounts		**TBC**

3.Technical Accounting Issues

Technical updates

There have been three technical accounting updates issued by Welsh Government since the last Audit, Risk and Assurance Committee meeting.

Update note 4 covered the following area.

- Task Force on Climate related Financial Disclosure (TCFD) aligned disclosure 2023-24. The PES paper providing guidance of the preparation of Annual Reports and Accounts (ARA) for 2023-24 highlighted a new requirement re TCFD aligned disclosure. The likelihood is that the phase 1 requirements will be applied by Welsh Government in 2023-24. A formal decision for the rest of Wales has not yet been made. Health Bodies were asked to submit and issues or concerns if NHS Wales were asked to implement this in 2023/24.

Update Note 5 covered the following areas.

- Final 2023-24 Audit Submission date – confirmed as 15th July 2024
- 2023-24 losses – all requests re novel/contentious issues to be submitted to Welsh Government by 13th March 2024
- Confirmation by the 28th of March that the 2023-24 charitable accounts for our organisation do not exceed the materiality threshold of £15m re assets, liabilities, income, and expenditure.
- 2023-24 NHS Charites Accounts – Leases – confirmation required by 19th February 2024 as to whether the ABUHB Charitable accounts include any operating or finance leases that under the FreM would fall within the scope of IFRS16. Email sent to WG 15.02.2024 in response this this request.
- Transfers in – S1 & S2 forms to be submitted by 28th March.
- Agreement of Balance Exercise – Month 11 – debtors statements to be issued by Monday 4th March 2024.
- 2023-24 Year-end arrangements with Welsh Government – invoices to be raised to Welsh Government by 5th March 2024 clarifying if payment is required in March.
- Last day for Cash payments between NHS Organisations – 19th March 2024 to be received by 21st March 2024. No further payments to be made unless agreed by the receiving organisation.

- Non-Cash Requests – final date for any changes to non-cash values including IFRS16 is 15th April (TBC).
- Arbitration deadlines – clarification of the process re agreement of balances and confirmation that invoice older than 17 weeks must not be included in the agreements. Last date to submit and arbitration case is 15.04.202.
- Year-end arrangements re Notional Pensions – same arrangements re last year with information being submitted by 12th April 2024. Information from the NHSBSA Pensions Division will be issued in March 2024.
- Cash arrangements – strategic and working balances cash support will be available for draw down from 15th March 2024. Cash returns to be submitted by 27th March 2024.
- Greenbury Information – Welsh government employees on secondment to be notified to WG so that they can request the relevant information.
- Return of LHB bank interest – interest net of bank charges is payable to WG. Returns to be submitted by 8th March 2024. No payment made by ABUHB.
- Welsh Risk Pool Returns – timetable to be discussed at the next WRP sub-group meeting on the 27th of February 2024.

Update Note 6 covered the following areas.

- WG confirmed receipt date for invoices to guarantee payment by 31st March 2024 – Monday 18th March 2024.
- 2024 PFI – notification of upcoming PFI data collection – to take place in May -July 2024.
- AGM deadline for 2023024 annual accounts – 30th September 2024.
- Welsh Risk Pool Returns – various dates between 8th April 2024 – 19th April 2024

4. Public Sector Payment Policy (PSPP)

The following table shows the Public Sector Payment Policy performance for the month of February 2024 and on a cumulative basis.

Category	Invoices	In Mth %	YTD %
NHS	Value Number	94.9 84.6	94.4 88.3
Non NHS	Value Number	98.3 98.2	97.1 97.3

The HB has achieved the target to pay 95% of the number of Non-NHS creditors within 30 days of delivery of goods/services in February and cumulatively.

There has been a slight decrease in the number & Value of NHS invoices paid within 30 days this month. NHS invoices in breach of the 30-day payment terms have been analysed for months 4-10. Divisions managers are in the process of being contacted

to make them aware of the non-compliance with a request to take the appropriate action.

5. Payments in Excess of £100K

There were no exceptional issues to report.

6. Standing Financial Instructions

There is no further update on the standing financial instructions.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is requested to note the report and approve the updated procedures:

- Accounts Receivable
- Counter Fraud Communication Strategy
- Contract Management

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 3.5 Record Keeping Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Finance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	FCP – Financial Control Procedure IFRS – International Financial Reporting Standards PSPP – Public Sector Payment Policy NWSSP – NHS Wales Shared Services Partnership LCFS – Local Counter Fraud Specialists WG – Welsh government TCFD - Task Force on Climate related Financial Disclosure PES – Public Expenditure System ARA – Annual Reports & Accounts TBC – To be confirmed
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment: • **Workforce** • **Service Activity & Performance** • **Financial**	**Is EIA Required and included with this paper?** A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following: Not Applicable Yes, outlined within the paper Yes, outlined within the paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.

	If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.

Aneurin Bevan University Health Board

Financial Control Procedure Accounts Receivable

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, Performance & Value

Issue date: DRAFT
Review by date: DRAFT
Policy Number: ABUHB/Finance/0239

Contents:

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Objectives.....Error! Bookmark not defined.
Scope.....Error! Bookmark not defined.
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1 Introduction

This policy covers the recovery of all monies due to Aneurin Bevan University Health Board and the correct accounting thereof.

2 Policy Statement

The policy sets out the requirements of the Health Board to ensure there are adequate controls in place to identify all sources of income due to the Health Board, to ensure it is promptly recovered and accurately accounted for. This Financial Control Procedure should be read in conjunction with Aneurin Bevan University Health Board's Standing Financial Instructions and the Recovery of Overpayments to Employees procedure.

3 Aims

The purpose of this document is to clearly set out the responsibilities of Health Board staff to ensure that all income due to the Health Board, which is not collected at the point of service or sale is:

- Invoiced to the appropriate debtor promptly and in accordance with agreed tariffs and other charging arrangements.
- All invoices should be processed through the Accounts Receivable department.
- Accounted for in the reporting period to which the income relates.
- Properly pursued with adequate arrangements for the collection of income due.

4 Objectives

The objective of this procedure is to clearly set out a control framework to ensure that all income due to the Health Board is identified, invoiced, collected within the Health Board's stated terms of payment (including referral to the Health Board's debt collection agency), and accounted for in the correct period.

5 Scope

This document relates to staff as follows:

- All staff and managers who raise income requests across the organisation.
- Staff within the Corporate Finance department who provide the cash and banking function for the organisation and those staff who are responsible for authorisation where appropriate.
- Staff within the Accounts Receivable function who raise invoices and chase payment thereof.
- Staff within the NWSSP payroll department with responsibility for raising income request forms relating to overpayments.

6 Roles and Responsibilities

6.1 Managers who generate income

Are responsible for:

- Initiating the raising of invoices, by the submission of a correctly completed and authorised income request form to the Accounts Receivable Department, to ensure that all income due to the Aneurin Bevan University Health Board is requested from the recipients of goods or services supplied.
- Ensuring that there is appropriate documentation available to support any agreements for goods and services provided in order to minimise payment disputes.
- Engaging in the resolution of disputes when invoices are not promptly paid.
- Directorate Managers are responsible for carrying out a periodical review to ensure that all sources of income are identified.

6.2 Central Management Accounts Team

Are responsible for:

- Completing the auto invoice upload spreadsheet with the mandatory information for each invoice.
- E-mailing the appropriately completed spreadsheet for upload to the ledger via the Auto Invoice process to the Accounts Receivable Officers. The email should state the number and value of invoices to be raised and have the auto invoice spreadsheet as an attachment.

- The Spreadsheet should show the PO number of the receiving customer, as appropriate. If no PO is available, the CMA team will endeavour to provide this in a timely manner, to assist the Accounts Receivable team to manage chasing the debt with the customer.
- The VAT treatment of each transaction will be considered and assessed prior to raising the invoice request.
- The CMA team should liaise with the Financial Services Manager – VAT to ensure the correct VAT treatment has been applied, and that any contracts relating to the income request are kept by the Financial Services Manager – VAT, in anticipation of any request made by HMRC to review the income transaction.

6.3 Accounts Receivable Manager

Is responsible for:

- Month-End closedown of the Accounts Receivable module in Oracle and production of all month end reconciliations and reports.
- Checking credit note requests to supporting information and applying the credit note to the invoice in the ledger.
- Referring debts to the Health Board's debt collection agency where appropriate.
- Reviewing the list of outstanding debts on a monthly basis with the Treasury Manager and Assistant Head of Financial Services and considering court action where appropriate and recommended by the Health Board's debt collection agency.
- Applying the NHS Arbitration process to NHS Wales debts.
- Preparing a schedule of debts for write off to be submitted for approval, see section 7.8.2.
- Reconciling the Accounts Receivable system to the general ledger prior to review by the Accountancy Manager.

6.4 Accounts Receivable Officers

Are responsible for:

- Checking all manual income requests received for correct completion, authorisation and VAT treatment.
- Raising invoices and credit notes from all requests received and either mailing hard copies in the post or emailing within 24 hours of production.
- Producing and sending 1st and 2nd Dunning letters on a twice weekly basis.

- Liaising with customers and payroll services re setting up payment plans for payment of invoices by instalment and dealing with any queries raised
- Production of a monthly schedule of outstanding invoices by budget holder, distribution and collation of responses.

6.5 Treasury Officers

Are responsible for:

- Receipting all cash received by the Health Board in payment of invoices raised and apply to the appropriate invoice in the ledger.
- Liaising with the Accounts Receivable Manager re any unapplied amounts to clear them and repay if necessary.

6.6 Accountancy Officer

Is responsible for:

- Receipting payments received via deduction from salary to the customer account against the invoice raised in the ledger.

6.7 Accountancy Manager

Is responsible for:

- Reconciling on a monthly basis, the Accounts Receivable system with the balance per the General Ledger.

6.8 Payroll Department

Is responsible for:

- Submission of timely income requests and the associated backing documents in relation to overpayments of salary, travel expenses and other payroll related payments. Submissions via payroll are made through the NWSSP – Overpayments Platform.
- Responding to queries from employees regarding salary related overpayments to facilitate prompt payment of invoices. Further detail regarding Payroll responsibilities can be found in the Recovery of Overpayment to Employees procedure.

7 Accounts Receivable

All income due to the Health Board which is not collected at the point of service or sale is:

- Invoiced to the appropriate debtor promptly and in accordance with agreed tariffs and other charging arrangements.
- Accounted for in the reporting period to which the income relates.
- Properly pursued with adequate arrangements for the collection of income due.

Invoices must be raised for all types of income due, except where alternative arrangements are in place or where the income has been collected at the time of service or sale.

The charges to be applied will be as determined by:

- Guidance issued by the Welsh Government, the National Health Management Executive or any other government department.
- Rates determined or agreements reached locally by officers of Aneurin Bevan University Health Board.

The Recovery of Overpayments to Employees procedure should be read in conjunction with this procedure in relation to the recovery of debts related to overpayments made via the salaries and wages system for staff.

An All-Wales NWSSP Overpayments procedure is currently being developed, which will sit alongside the local Health Board's procedure.

Bills that are not paid in accordance with the procedure set out for timely recovery of debts will be referred to the Aneurin Bevan University Health Board's debt collection agency and in the event of continued non-payment will be considered for civil court action for debt recovery where cost effective to do so and based on the advice of the Health Boards debt collection agency.

Separate procedures are in place for Welsh NHS bodies and other public bodies.

To maintain internal control, Officers responsible for the Accounting and Control of Accounts Receivable should not also receive and account for cash or cheques

7.1 Procedure for requesting and raising an Invoice

7.1.1 The sources of information to enable an Accounts Receivable account to be raised are:

- An Income Request Form (Appendix A)
- Auto-Invoicing
- NWSSP - Overpayments Platform

7.1.2 All requests to raise an invoice by Managers, who are responsible for notification of income due, must be forwarded to the Accounts Receivable department by one of the sources identified in Paragraph 7.1.1 above and must contain the following information:

- Name and telephone extension number of the requesting officer
- The full name and address, including the postcode, of the debtor
- If the debtor is a company or other organisation, the name of the person to whom the invoice should be directed.
- The Oracle customer number for the debtor, if known
- A telephone number, and email address if possible
- Full details of the charge to be made, together with any appropriate backing documentation.
- A valid Purchase Order number from the customer, in line with All Wales No PO No Pay, where applicable.
- The amount to be billed, with VAT applicable shown separately
- The financial code to which the income is to be credited.
- Named individual within ABUHB to be contacted in the event of a query on the invoice (FAO), including contact number and/or email address.

7.1.3 When invoices are raised, managers must ensure that there is appropriate documentation available to support any agreements for goods and services provided to the customer. This documentation must be issued to the Financial Services Manager – VAT, to ensure the correct VAT treatment has been applied, prior to the invoice being raised. This will minimise later payment disputes. To this end this policy ensures that the manager who initiates the invoice will be engaged in the resolution of disputes when invoices are not promptly paid.

7.1.4 All requests for an invoice to be raised must be authorised by the requesting officer (other than Auto-Invoicing) and forwarded to the Accounts Receivable department for action.

7.1.5 The Accounts Receivable department will be responsible for ensuring that invoices are raised for all requests of income due to the Aneurin Bevan University Health Board.

7.1.6 On receipt of the Income Request form (See Appendix A), the Accounts Receivable Manager, or Accounts Receivable Officer should ensure that the form is correctly completed and authorised

by the requesting officer. Incomplete or unsigned requests are to be returned to the originator for completion (There is no requirement for this with Auto-Invoicing). The Officers should also check the correct treatment of VAT is indicated on the form and inform the originator where this is different. A customer number is then allocated and documented on the requisition form.

7.1.7 The Income Request forms or other sources as per paragraph 7.1.1 are sorted by the Accounts Receivable Officer, and sequentially numbered (requisition number). The total of this batch is to be calculated and entered on to the Batch Control Register.

7.1.8 The information from each batch of Income Request forms, or other sources as per paragraph 7.1.1, shall be input into the Oracle Accounts Receivable system. After inputting each request in the Oracle Accounts Receivable system, the Accounts Receivable Officer is to enter the date invoice is raised and the invoice number on to the Income Request form or other source of notification, and stored electronically.

7.1.9 On completion of the batch, a batch header shall be generated, detailing control value and number of invoices raised.

7.1.10 The Accounts Receivable Officer should complete a batch header and check that the batch totals reconcile to the Batch Control Register.

7.1.11 The batch header, hard copy invoices and original income request form should be passed to and checked by a member of the Accounts Receivable department, other than the person inputting the Income Request Forms to which the batch relates. Appropriate action should be taken for any invoices where discrepancies to the Income Request Form are identified. The officer checking accuracy should sign the batch header.

7.1.12 The Invoices should be dispatched to the debtor within 24 hours of production. Hard copies of invoices are not kept in the office but may be reprinted from the Oracle Accounts receivable system at any point in time.

7.1.13 The Income Request Forms are scanned (with any associated Backing documentation) to the Invoice on the Oracle Accounts Receivable module. All Income Request Forms in a single Batch are scanned to the Batch Header, and an electronic copy is retained. Hard copy requests are no longer retained.

7.1.14 The Health Board has implemented the Auto-Invoicing process within some departments to facilitate the raising of invoices.

Auto-Invoicing uses an interface to upload invoices directly into the Oracle Accounts Receivable system, through a template. The correct completion of the template is the responsibility of CMA. The information on the auto-invoicing template should match the detail required on the invoice request form, as detailed in 7.1.2. Once the template is complete and validated, it is transferred into Oracle by the Accounts Receivable Officer and a new Batch of invoices is created.

The Accounts Receivable team will be notified by CMA, via email, that a new batch of invoices is ready to be imported into Oracle. The email will include the total number of invoices in the batch, the total batch value, and the file name of the batch. The Accounts Receivable team will ensure that the batch is imported into Oracle successfully, and the invoices are printed or emailed and sent to the customers.

The Accounts Receivable team will notify the requester, via return email, of the success of the batch, confirming the total number of invoices raised, and the total value of the batch.

If there are any issues with the batch, the batch will be cancelled by the Accounts Receivable team and returned to the requesting officer for review. The batch will then need to be reviewed, amended as required and re-entered as a completely new batch.

The full Auto-Invoicing procedure details the step-by-step guide for implementing Auto-Invoicing (Accounts Receivable – Auto Invoice Process).

7.1.15 The NWSSP – Payroll department have developed an overpayments platform to monitor and raise overpayments of salary. When an overpayment of salary has been calculated, the Payroll department will complete a Microsoft Form which is reviewed and verified by a Senior Payroll Officer, before being submitted and uploaded to the NWSSP – Overpayments Platform.

In the first instance the Payroll Team will refer an overpayment to the ABUHB Counter Fraud Team for consideration where the overpayment is over £5k and/or longer than three months in duration. The Payroll Team will only proceed with an overpayment notification on confirmation that ABUHB Counter Fraud Team give an instruction to continue with the overpayment process.

The submission of a new overpayment onto the platform sends a notification to the Accounts Receivable team via TEAMS, that a new income request has been created and uploaded to the platform.

The Accounts Receivable team then utilise the detailed information on the platform to raise a new invoice for the overpayment of salary as per the process described above.

The invoice, alongside the associated Overpayment of Salary letter from the NWSSP – Payroll Services department and backing information will then be sent out to the recipient.

Once the invoice has been raised, the Accounts Receivable team update the Overpayments Platform to confirm the invoice number and date of issue.

The NWSSP - Overpayments Platform is available to the Workforce team, in the form of a BI Reporting Tool, who are able to review the reason, department, manager and value of all overpayments that have occurred throughout the Health Board.

7.2 Notification of Payments

7.2.1 Hospital Cashiers/Finance Cashiers who receive payment of an invoice are to record as much detail as possible on the Cash Receipts and Bank Deposit (C & D) sheet and always the invoice number if available. These entries must be coded to the Accounts Receivable control code. The officer receipting cash only has write access to the receipting, with view only access to other Accounts Receivable functions.

7.2.2 The Finance Cashier will produce a receipt batch print identifying all receipts received and where appropriate the Accounts Receivable invoice number the amount has been applied to.

7.2.3 Cash receipts received that are unable to be allocated to an invoice number will be receipted against the unapplied code .This will also apply to credit transfers. Copies of the relevant statements and/or remittance advice shall be made available to the Accounts Receivable Manager by the Cashiers department for reconciliation of the unapplied receipts register.

7.2.4 The appropriate Finance Officer in Financial Accounts shall receipt payments obtained via deductions from salary to the customer account (accounts receivable receipt code). A copy of the deductions list should be forwarded to the Accounts Receivable Manager from the Payroll Manager.

7.2.5 The Cashiers Department will enter the payments received for invoices, from all sources into the Oracle Accounts Receivable system, through the receipting module.

7.2.6 Any payments received that differ in value from the invoice raised are to be investigated by the Cashiers department / Accounts Receivable Manager and the appropriate action taken to clear these amounts. All refunds to be processed using the debit memo functionality in Oracle and processed via Accounts Payable.

7.2.7 On completion of the posting of each batch of receipts, the Cashier shall produce a receipt register. This should be filed and where appropriate the paying in slip attached.

7.2.8 The amounts posted against the computerised Accounts Receivable system must be reconciled on a monthly basis with the amounts coded to Accounts Receivable receipts in the general ledger. The Assistant Head of Financial Accounting should undertake the Accounts Receivable reconciliation. This officer should not have access to be able to post receipts on the Oracle Accounts

Receivable system. The Accounts Receivable Reconciliation should be checked and authorised by the Assistant Head of Financial Services and Accounting. Any discrepancies should be investigated and cleared by the Accountancy Manager.

7.2.9 The Head of Financial Services and Accounting will have access rights to all Oracle functionality in order to ensure that operational issues are resolved quickly.

7.3 Requesting and issuing of Credit Notes

7.3.1 Any credit note requested must be authorised by the requisitioner that requested the original invoice to be raised, and it is their responsibility to inform the Accounts Receivable department when there is a need to amend or cancel an invoice.

All requests for a credit note to be raised must be authorised by the requesting officer (other than internal e-mail requests or for Auto-Invoicing) and forwarded to the Accounts Receivable department for action.

7.3.2 All requests to amend or cancel an invoice must be made on a Credit Note Request Form (Appendix B) or by E Mail.

7.3.3 The following details must be stated on the Credit Note Request Form by the authorised requesting officer:

- Name and telephone extension number of the requesting officer
- The Invoice Number
- Customer Number
- The Original Invoice Value
- The Credit Note Value
- The Revised Invoice Value
- The reason for amending or cancelling the invoice
- The Financial code to be debited

7.3.4 On receipt of the Credit Note Request Form, the Accounts Receivable Manager or Accounts Receivable Officer should ensure that the form is correctly completed and authorised by the requesting officer. Incomplete or unauthorised requests are to be returned to the originator for completion. (There is no requirement for this with Auto-Invoicing).

7.3.5 An officer within the Accounts Receivable department will sort the Credit Note Request Forms. The credits are checked for Customer numbers and that the amount to be credited is still outstanding on the ledger.

7.3.6 The information from each batch of Credit Note Request Forms shall be input into the Oracle Accounts Receivable system. After inputting each request, the Accounts Receivable Officer is to enter the Credit Note Number and the date actioned on the Credit Note Request Form and sign it.

7.3.7 On completion of the batch, hard copies of the credit invoices are printed prior to dispatch. Appropriate action should be taken for any amendments or cancellations deemed to be incorrect by the Accounts Receivable Manager.

7.3.8 The Accounts Receivable manager applies the credit to the appropriate invoice then checks the credit notes.

7.3.9 The Credit Notes are shown as an individual document. The original invoice and credit notes are printed and dispatched as appropriate. Hard copies of credit notes are not kept in the office but may be reprinted from the Oracle system at any point in time.

7.3.10 The batch header document, and any supporting documentation are scanned and filed electronically per batch.

7.4 Debt Collection – Treatment of Invoices Unpaid

7.4.1 The standard debt collection process is as follows:

7.4.1.1 On a twice weekly basis a 1st Dunning letter will be sent out to the individual for any invoice which remains outstanding for 21 days from the date of the invoice (See Appendix C).

7.4.1.2 Where no response has been received to Dunning letter 1 (as above), after a further 21 days a 2nd and final Dunning letter is issued to the individual stating that after 14 days the Debt will be referred to The Health Board Debt Collection Agency.(See Appendix D)

7.4.1.3 At the same time as the second Dunning letter is issued, the requesting manager is also contacted to help facilitate the process and inform of any disputes that may have arisen with the Customer.

7.4.1.4 If payment is not received within 14 days of the second Dunning letter, there is no further information, or the manager has not replied, the Accounts Receivable manager will refer the debt to the Health Boards Debt collection agency for them to pursue the debt on behalf of the Health Board.

7.4.1.5 On a monthly basis all debts outstanding and referred to the debt collecting agency will be reviewed in a meeting with the Assistant Head of Financial Services, Treasury Manager and Accounts Receivable Manager. A decision will be taken on whether to refer any outstanding debts for court referral. This referral will be based on the debt collection agency's advice and likelihood of court action success. Where necessary, decisions will be escalated to the Head of Financial Services & Accounting.

7.4.2 Exceptions to the standard process:

7.4.2.1 The Recovery of Overpayments to Employees procedure should be read in conjunction with this procedure, For other outstanding debts relating to Health Board employees and former Health Board Employees e.g. mobile phones, lease cars, the standard debt collection procedure will be applied..
An All-Wales NWSSP Overpayments procedure is currently being created, which will sit alongside the Health Board's local procedure.

7.4.2.2 NHS Organisations – Welsh – All Welsh NHS bodies are subject to the arbitration process set out by Welsh Government and must adhere to this policy when chasing outstanding debts. The Welsh

Health Circular (WHC (2022) 013) detailing the roles and responsibilities of each NHS Wales Organisation is updated on a bi-annual basis.

7.4.2.3 NHS organisations Non Welsh – Statements and copy invoices are sent monthly. A list of all outstanding invoices will also be sent to the requestor, to inform them of the outstanding debt, and help facilitate any disputes. The Accounts Receivable Manager will also contact the NHS organisation concerned by email or telephone to ascertain the reason for non-payment providing the invoice has not been raised in error, telephone calls or email contact shall continue until such a time as the invoice is settled.

7.4.2.4 Other Public Bodies

The procedure for the collection of debts from other public bodies is laid out in Appendix E & F.

7.4.2.5 Research & Development Invoices

Standard Research & Development contracts include 45 day payment terms.

On a twice weekly basis a final Dunning letter will be sent out to the debtor for any invoice which remains outstanding for 45 days from the date of the invoice (See Appendix D). This letter states that after 14 days the debt will be referred to The Health Board Debt Collection Agency.

At the same time as the second Dunning letter is issued, the requesting manager is also contacted to help facilitate the process and inform of any disputes that may have arisen with the customer.

If payment is not received within 14 days of the second Dunning letter or there is no further information, or the manager has not replied the Accounts Receivable manager will refer the debt to the Health Boards Debt collection agency for them to pursue the debt on behalf of the Health Board.

7.4.2.6Reporting of Overseas Visitors Outstanding Debts.

As per the Overseas Visitors procedure, the Health Board is responsible for raising invoices to patients identified as overseas visitors. .

The Health Board is also required to report any outstanding debt to the Department of Health & Social Care (DHSC).

On a monthly basis the Treasury Manager is responsible for reviewing all outstanding debt identified in this category and updating, as required, any changes in debt status that have been identified.

This includes notifying DHSC of:

- new debts raised that exceed the reporting threshold (£500),
- updating debts that have been paid in full,
- updating debts where a repayment plan has been agreed,
- any other changes to the debt status.

7.5 The Health Board's Debt Collection Agency

7.5.1 All debts referred to the Aneurin Bevan University Health Board's Debt Collection agency should be referred as per the signed agreement between Aneurin Bevan University Health Board and the contracted Debt Collection Agency.

7.5.2 The contracted Debt Collection Agency undertake to:

- Approach debtors referred by letter, email and telephone only.
- Provide progress reports on each case.
- Remit all monies collected promptly.
- Charge for successful UK recovery services.
- Seek approval in advance for any "in person" site visits to debtors.

7.5.3 The Aneurin Bevan University Health Board undertakes to:

- Pay contracted Debt Collection Agency for all agreed services rendered and within agreed time limits as detailed on the supplier invoice.
- Provide any information requested by the contracted Debt Collection Agency, if possible.
- Inform the contracted Debt Collection Agency of any payments which have been received by the Local Health Board, in respect of invoices referred to them.
- Inform the contracted Debt Collection Agency on the Local Health Board's agreed courses of action in respect of any debts referred to them, when necessary.

7.6 Payment by Instalments

7.6.1 Any enquiry to pay by instalments will be reviewed by the Treasury Manager and Assistant Head of Financial Services.

Payments by instalments, where possible, shall be limited to a period of 12 months and should be by standing order or payroll deductions. Where there are special circumstances, the period, amount payable by instalment, and method shall be at the discretion of the Assistant Head of Financial Services. (In the absence of the Assistant Head of Financial Services, the decision will be made by the Head of Financial Services and Accounting.)

Where customers have requested to pay by instalments, the Health Board will issue an invoice for an Administration Charge of £1 per month for every month of instalment.

7.6.2 In the case of overpayments of salary, where payments by instalments are requested, the recovery of Overpayments to Employees procedure should be followed (see section 7.4)
An All-Wales NWSSP Overpayments procedure is currently being created, which will sit alongside the Health Board's local procedure.

7.6.3 The Health Board will issue an invoice for an Administration Charge of £1 per month for every month of instalment from the end of the 'matching period.'

7.7 Court Action

7.7.1 If all attempts to recover the debt via the usual follow-up procedure have failed consideration shall be given to take the debtor to court. The decision on whether to take this course of action shall depend on:

- The circumstances of the debt and the likely success. Advice from the Local Health Board's Debt Collection Agency shall be taken into account.
- The value of the debt.

7.7.2 The decision on whether to apply for court action shall rest with the Head of Financial Services and Accounting.

7.8 Write Off Procedure

7.8.1 Only Non NHS invoices can be written off. The NHS Manual for Accounts states that NHS Debts cannot be written off. If an NHS Debtor refuses to settle an account, negotiations should take place in an attempt to resolve the disputed amount in line with the Welsh Government Arbitration procedure which all Welsh NHS bodies

must adhere to. For all English NHS disputed invoices meetings should be held with the appropriate parties to reach a satisfactory conclusion.

7.8.2 Those Non NHS Invoices which are proposed for write off should be detailed on a schedule prepared by the Accounts Receivable Manager. The Accounts Receivable Manager, on a bi-monthly basis, will review outstanding debts that have been classed as a "Bad-Debt", and prepare a schedule, providing the following information:

- Invoice Number
- Invoice Date
- Invoice Type, e.g. Private Patient, Prescription Charge
- Debtor Name
- Original Amount with VAT identified separately
- Amount Outstanding with VAT identified separately
- Reason for the Write off

7.8.3 The Health Board has introduced an Approval Hierarchy, based on the value of the bad debt that is proposed for write off. The Approval Hierarchy is as follows, and contains 6 Authorisation levels:

Authorisation Level	Responsible Officer	Lower Limit	Upper Limit
1	Assistant Head of Financial Services	£0	£10
2	Head of Financial Services & Accounting	£10	£50
3	Assistant Director of Finance (Financial Systems & Services)	£50	£2,500
4	Executive Director of Finance	£2,500	£25,000
5	Audit Committee	£25,000	£50,000
6	Welsh Government	£50,000	No Upper Limit

7.8.4 The Accounts Receivable Manager will prepare a schedule with proposed write-offs for each Approval Level. Each schedule will be sent to Assistant Head of Financial Services, who will then review the proposed write-offs, and provide approval as appropriate.

7.8.5 For those write-offs that require further approval (i.e. Write-offs over £10), the schedule will be sent to each Responsible Officer in the Approval Hierarchy in turn, based on the value of the debt.

For example, if there is a debt of £1,000 proposed for write-off, the Assistant Head of Financial Services and Head of Financial Services and Accounting will review and approve the write off in turn, before

it is sent to the Assistant Director of Finance (Financial Systems & Services) for final approval.

7.8.6 Once final approval for each debt has been provided, the write-offs can be processed on the system by the Accounts Receivable Manager, who will receive the signed certification from the final authoriser.

7.8.7 The debts which have been approved for write-off will be reported to the Audit Committee on a periodic basis, detailing the total number of debts per authorisation level, and the total value of the debts.

7.8.8 Invoices will only be put forward for write off once every option for recovering the debt has been pursued and where the Health Board's debt collectors have recommended that court action is not viable.

8 Implementation

This document should be implemented with immediate effect.

9 Further Information

Enquiries regarding this policy should be directed to the Treasury Manager, Assistant Head of Financial Services, Head of Financial Services and Accounting or the Assistant Director of Finance (Finance Systems and Services).

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 A

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

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

INCOME REQUEST FORM

*** For Attention Of:**	
*** Customer Name:**	
Customer Email:	
Customer Telephone:	
*** Customer Address:**	
*** Post Code:**	
Purchase Order Number	

*** Please Tick as Appropriate:**

Invoice to be Sent out Direct	
Invoice to be returned to Requesting Officer	
Backing information to be sent out	

Details to Appear on Invoice:

	* Line Description	* VAT	* Value £
1			
2			
3			
4			

*** Account Code for Invoice to be raised:**

Entity	Cost Centre	Subjective	Analysis	Unit	VAT	Value £
040						
040						
040						
040						

*** Requesting Officer:**	
*** Contact Telephone:**	
*** Contact Email:**	
*** Signed:**	
*** Budget Holder Name:**	
*** Signed:**	
*** Date:**	

Accounts Receivable Use Only:

Account Number:	
Date Raised:	
Invoice Number:	

* Fields marked with * are mandatory

Appendix B

Credit Note Request

FROM:

TO: ACCOUNTS RECEIVABLE, FINANCE DEPARTMENT,

C BLOCK, MAMHILAD PARK EST, PONTYPOOL.PLEASE WOULD YOU ISSUE A CREDIT NOTE AGAINST THE FOLLOWING INVOICE:

INVOICE NO.: _____ DATE RAISED:_____

NAME OF DEBTOR: _____

CUSTOMER NO: _____

	AMOUNT	
	£	p
ORIGINAL INVOICE VALUE:		
CREDIT NOTE VALUE:		
REVISED INVOICE VALUE:		

REASON FOR ISSUING CREDIT NOTE

SIGNED: _ DATE: _____

THIS REQUEST MUST BE APPROVEDY A SENIOR MANAGER

ACCOUNTING CODE					Amount		For Debtors Section Use Only
					£	P	
040							**Credit Note Number**:
040							
040							**Date Actioned**:
040							
040							**Signed**:
040							

Appendix C

1st Dunning Letter

Appendix D

2nd Dunning Letter

Appendix E

Disputed Debts between ABUHB and Local Authorities

Summary

1. This guidance is intended to facilitate the resolution of invoices in dispute between the ABHB and the Local Authorities.

2. The implementation timetable has been designed to ensure that no debts remain outstanding for more than 56 days. This procedure will apply to all invoices regardless of the value.

3. The Health Board has issued a revised debt chasing procedure whereby Managers (authorised signatories) are asked to chase debts if they remain outstanding for more than the allocated payment period of 21days.

4. It is anticipated that most debts will be agreed and paid within this timeframe and that this procedure will only apply to any invoices where disputes are notified regarding the value or period that the invoice covers.

Scope

5. This procedure will apply to all Welsh Local Authorities.

Procedure & Implementation

6. The timetable for action in relation to disputed debts is outlined below:

Age of Debt (days)	Action	Responsibility
0-21	Invoice raised and awaiting payment.	Requisitioner and Accounts receivable Staff.
22 (1st Dunning letter)	1st dunning letter sent to debtor chasing payment. Authorised signatory/Manager to be notified of the outstanding debt for them to liaise with their counterpart in the billed organisation to secure payment.	AR staff and Authorised signatories/Managers.
44 (2nd Dunning letter)	2nd level dunning letter sent chasing payment and notification of referral to DoF after 14 days if the invoice remains unpaid. Authorised signatory/ manager to establish when invoice will be paid or to resolve any outstanding disputes to facilitate the payment of the invoice.	AR staff and Authorised signatories/managers.

56+	Refer to the Director of Finance if no information has been received from the Manager to say otherwise. Failing this consider court action.	Director of Finance to be notified of non-payment to contact counterpart in billed organisation to reach agreement and invoice paid.

Appendix F

Government Bodies Escalation Process Submission Proforma

Submitting Organisation:
Creditor Organisation:
Debtor Organisation:
Invoice Date:
Invoice Ref:
Invoice Amount:
Reason for Invoice:
Evidence of verbal discussions between parties: **Confirm if included within Attachment or Within Main Case Section**
Evidence of written discussions between Chief Executives: **Confirm included within Attachment**
Case Submission Date:
Director of Finance Signature:

Aneurin Bevan University Health Board

Counter Fraud Communication Strategy

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

Issue date: DRAFT
Review by date: DRAFT

Contents:

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1. Introduction

1.1 This Communication Strategy has been established to enable and support communication and engagement to promote and raise awareness of the NHS counter fraud initiative, including the publicising of proven NHS fraud cases and media handling within and outside the Health Board.

1.2 The Local Counter Fraud Specialist (LCFS) is committed to ensuring that effective communication is undertaken to deter fraud and prevent the organisation from falling victim to fraudulent practices which divert much needed NHS resources from patient care. Through publicity, education and training, the organisation seeks to change attitudes to and perceptions of NHS fraud. The message will be that fraud is not a victimless crime and that active co-operation of all is necessary to prevent valuable resources being diverted through fraudulent activity.

1.3 The LCFS will work with staff who already have effective communication approaches in place which may be used to publicise, educate, and train staff throughout the organisation.

1.4 The types of communication used by the LCFS will be reported to both the Director of Finance, Procurement & Value and the Audit, Risk and Assurance Committee, along with assessments of how effective this work has been.

1.5 The Communication Strategy concentrates on the following communication areas:

- Media and External Awareness Raising
- Local promotion of fraud awareness within all areas of the Health Board.

1.6 The Director of Finance, Procurement & Value should be consulted about any conflicts that arise in respect of this communications strategy. The Assistant Director of Communications and Engagement will also be consulted on communication approaches.

1.7 This communications strategy is open to review and continual improvement, particularly in light of further experience and new developments. Countering fraud will require a comprehensive approach from everyone who works in and around the organisation.

2. Background

Welsh Government Directions to NHS Bodies on Counter Fraud Measures outline the need for due regard to be paid to any guidance and advice on media handling of counter fraud matters issued by the NHS Counter Fraud Authority (NHSCFA).

2.2 The Chartered Institute of Public Finance and Accountancy (CIPFA) strategy document *'Managing the Risk of Fraud'* identifies the need for the organisation to have a clear programme of work to publicise the role of the LCFS and sanctions imposed on proven perpetrators of NHS fraud.

2.3 The NHS anti-fraud manual identifies three key principles of action. The first key principle for NHS anti-crime work involves the creation and development of an anti-fraud culture. This is achieved by proactive work to inform and involve those who work for or use the NHS about economic crime, how to tackle it, with a view to increasing understanding of the impact of economic crime against the NHS. To create such a culture, there needs to be effective communication about the LCFS role and sanctions imposed for proven perpetrators of NHS fraud so that potential fraud is deterred. This can be accomplished through communications and promotions such as public awareness campaigns or through media engagement to change the culture and perceptions around economic crime so that it is not tolerated at any level.

3. Communicating with the Media

The Assistant Director of Communications and Engagement or Head of Communications will receive an advance warning from the LCFS if there is a possibility of external interest in any potential fraud investigation or fraud awareness event. Appropriate measures may need to be put in place to protect the organisation from adverse publicity and ensure continuity of patient services/care.

3.2 The Assistant Director of Communications and Engagement and/or Head of Communications should contact the NHS Counter Fraud Authority media team when formulating a press response in relation to fraud and corruption issues. This is because the request for information is likely to impact on both organisations.

3.3 All press releases relating to fraud and corruption will initially be agreed with the Assistant Director of Communications and Engagement and/or Head of Communications in liaison with the LCFS and NHS Counter Fraud Authority. Such communications allow members of the public to become aware of the anti-fraud initiative and the role of the LCFS.

3.4 The NHS Counter Fraud Authority will promptly brief the Assistant Director of Communications and Engagement and/or Head of Communications on any other contentious issue in relation to fraud and corruption which is likely to attract interest from the media. Public interest/safety should always be the ultimate consideration when deciding whether to be proactive in these circumstances by releasing information or issuing a reactive statement.

3.5 Despite best efforts, the media may become aware of inappropriate information about an ongoing fraud or corruption investigation. If this situation does occur, it can sometimes result in the media running inaccurate stories about investigations. In such cases, the Director of Finance, Procurement & Value should be contacted immediately so that, in liaison with the NHS Counter Fraud Authority, the best course of action can be determined. The NHS Fraud Authority/Health Board/LCFS will need to liaise closely to ensure that resulting stories are not misrepresentative or damaging to the investigation or reputation of the organisations and people involved.

3.6 Any media enquiry about fraud or corruption received by the LCFS will be directed to the Assistant Director of Communications and Engagement and/or Head of Communications in the first instance. This will ensure a consistent approach across the Health Board.

3.7 Any request to the LCFS for a media interview will be directed to the Assistant Director of Communications and Engagement and/or Head of Communications, ensuring that it is handled promptly, and the most appropriate person interviewed. Requested media interviews about the LCFS role, etc will be notified to the Assistant Director of Communications and Engagement and/or Head of

Communications as a matter of courtesy in case there is further interest from other media groups.

4. Local Promotion of Fraud Awareness

To promote the role of the LCFS and create an anti-fraud culture, the LCFS will use various communication methods around the organisation. These will inform, educate, and train staff, patients and visitors about the effect fraud can have on patient care and how to report any knowledge or suspicions of potentially fraudulent activity.

4.2 The communications undertaken by the LCFS are designed to cover the following areas:

- **Inform and involve** – this involves working with NHS staff, stakeholders, and the public to change the attitudes to and perceptions of fraud within the organisation so that there is a willingness, and confidence, to report any knowledge or suspicion of fraud. The need to protect the organisation from fraudulent activity needs to be seen as the joint responsibility of everyone within the organisation. The aim is to highlight the risks and consequences of crime against the NHS.
- **Prevent and Deter** – This sets out the requirements in relation to discouraging individuals who may be tempted to commit crimes against the NHS by ensuring that opportunities for crime to occur are minimised. It also includes ensuring that systems being operated are not open to fraud occurring unchallenged or undetected. It involves raising awareness of the types of fraud that may occur and communicating this to line managers, budget holders, risk groups, audit committees and auditors of organisations. Deterrence is linked to the creation of an anti-fraud culture in that peer group pressure can make potential fraudsters feel that what they are contemplating is unacceptable. The deterrent factor is about the extent to which potential fraudsters believe that if fraud is attempted it will be detected and prevented from succeeding. It also relies on communicating the message that full sanctions (including criminal action) will be considered, without exemption, and appropriate action taken against any perpetrator of NHS fraud.
- **Hold to Account** – This incorporates the requirements in relation to detecting and investigating crime, prosecuting

those who have committed crimes and seeking redress. It involves enforcing the message for all staff to remain vigilant and open to the possibility of fraud being attempted. The LCFS will need to communicate to all staff what action to take if a potential fraud has been detected, as inappropriate, well-intentioned actions may compromise the pursuit of full sanctions if fraud can be evidenced. This type of communication needs to emphasise Health Board support for staff who report such concerns so that confidence in the system can be maintained. To underpin the above messages, the LCFS will publicise proven cases of NHS fraud that has occurred both locally and nationally. Communication in this area enhances the message that fraud within the NHS will not be tolerated and that the organisation, and NHS, will pursue full sanctions whenever appropriate to do so.

- **Strategic Governance** – This sets out the standards in relation to the organisation's strategic governance arrangements. The aim is to ensure that anti-crime measures are embedded at all levels across the organisation.

4.3 The effectiveness of the communication methods explained in 4.2 will be assessed by using a local annual staff survey issued to a sample of staff across the organisation. The results of this survey will be reported to the Director of Finance, Procurement & Value and will inform future work undertaken by the LCFS.

4.4 Appendix 1 details the communication methods and action plans to meet specific target audiences. Any other types of communication available around the organisation should be brought to the attention of the LCFS so that they can be added to the appendix.

5. Contact Points

5.1 Any concerns about work related to fraud and corruption should be communicated to the LCFS, who can be contacted on **01495 765470** or email **CounterFraud.ABB@wales.nhs.uk**

5.2 There is also the NHS Fraud and Corruption Reporting Line on **0800 028 40 60** to which knowledge or suspicion of NHS fraud can be reported (anonymously if preferred) or likewise via the online reporting tool **www.reportnhsfraud.nhs.uk**

5.3 The NHS Counter Fraud Authority media team can be contacted via email on media@nhscfa.gov.uk

5.4 Further information can be found on the Local Counter Fraud intranet site, in its Raising Concerns Policy, Counter Fraud Bribery and Corruption Policy, or from the NHS Counter Fraud Authority

Appendix 1 Internal/External Communication Opportunities

Target Audience	Key Messages	Actions	Frequency	Responsibility
Health Board	Demonstrate that the Board is accountable for fraud in the NHS	Message from Chief Executive to be included in board briefing	1 per annum	LCFS & Director of Finance, Procurement & Value
Audit, Risk and Assurance Committee	Update the committee on progress of the Counter Fraud work plan	Regular update reports for the Audit, Risk and Assurance Committee	4 per annum (Quarterly updates)	LCFS
		Annual Report including compliance with the Welsh Government directions	1 per annum	LCFS
New Staff	Promote the role of the LCFS	Fraud Awareness presentation included in Induction programme	12 per annum	LCFS & Training & Development
		Information included in Induction packs	Packs to be updated Annually	LCFS & Training & Development
All Staff	Promote the role of the LCFS Publicise Successful local and national cases	Include article in Team Brief	1 article per annum	LCFS & Assistant Director of Communications and Engagement and/or Head of Communications
		Include article in specialist newsletter	Target higher risk groups 1 article per annum	LCFS

Target Audience	Key Messages	Actions	Frequency	Responsibility
		Include in customised fraud awareness presentations (Departmental)	As required	LCFS & Department Managers
		Include in Counter Fraud newsletter	As required	LCFS & Assistant Director of Communications and Engagement and/or Head of Communications
		Counter Fraud webpage included on staff intranet	Information to be updated monthly	LCFS & IT
Managers & Supervisors	Risks of Fraud	Fraud Alerts	As required	LCFS & Assistant Director of Communications and Engagement and/or Head of Communications
		If Key risk identified meeting to be held with Manager responsible	As required	LCFS & Department Managers & Supervisors
		Regular meeting with Risk group	To be agreed (Risk group to be identified)	LCFS & Risk Manager & Supervisor
Staff, Visitors & Patients	Encourage people to report fraud suspicions	Counter Fraud posters & leaflets on display at various locations	Walk around to replenish stock x 2 per annum	LCFS

Target Audience	Key Messages	Actions	Frequency	Responsibility
	Give positive image that NHS are dealing with fraud	Event to be organised in conjunction with fraud awareness programme	3 per annum	LCFS
NHS Contractors	Promote the role of the LCFS Publicise Successful local and national cases	Publicity Packs to be distributed (Posters & Leaflets)	1 per annum	LCFS
		Presentations to be delivered to Key Stakeholder groups	6 per annum	LCFS & Primary Care Director
		Newsletter to be circulated	2 per annum	LCFS

Aneurin Bevan University Health Board

Contract Management Financial Control Procedure

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, Procurement & Value

Issue date: DRAFT
Review by date: DRAFT
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1. Introduction

This policy should be read in conjunction with the Procurement and Financial Control Procedure for Aneurin Bevan University Health Board (ABUHB).

A consistent approach to contract management is designed to ensure ABUHB's awarded contracts via third party suppliers are managed appropriately making best use of resources, mitigating against known risks and demonstrating value for money. Achieving this will deliver organisational benefits to ABUHB and help achieve contract compliance. This policy sets out the process contract managers should adhere to in order to meet the business, operational and policy objectives required from the contract.

2. Policy Statement

A significant proportion of the financial resources available to ABUHB are used to procure service delivery requirements from third parties. Contract management is the process and methodology which ensures that both parties, ABUHB and external providers, meet their contract obligations as efficiently and effectively as possible in order to meet the business, operational and policy objectives. It is important that ABUHB manage the third parties in a consistent, effective and professional manner whilst adhering to responsible and ethical behaviours.

Following procurement activity and a contract being placed with a third party, the contract and relationship needs to be managed to ensure that ABUHB receive the goods and services on the terms set out in the contract. The nominated contract manager in ABUHB is responsible for the management and performance of these contracts. All significant contracts for goods and/or services must be governed by either a contract specific service level agreement and through supplier performance measurement and reporting mechanisms.

The approach to contract management at ABUHB is based on proportionality and risk management. All Contracts which have an overall contract value greater than £100,000 (Inclusive of VAT and extension options) will have a designated contract manager within the budget holders business area. Other lower value contracts require to be reviewed by the budget holder to determine their business criticality through effective risk management. If these contracts are deemed to be high risk and business critical, there will be a designated contract manager.

For contracts with an overall contract value of greater than £100,000, a Contract Management Plan will be developed jointly by the Procurement Lead and the budget lead of the buying department. This plan will be used

to outline the roles and responsibilities, key aspects of the contract and the contract management provisions. It is the responsibility of the service contract manager to ensure the Contract Management Plan is updated regularly, throughout the life of the contract, detailing the changes and revisions to the contract and keep procurement informed of any updates or changes.

The contract manager must perform regular contract reviews to maximise operational performance, alignment to financial obligations, ensure social, economic and environmental benefits are met.

The Contract Management Plan will identify various elements including (but not limited to):

- ABUHB and 3rd Party lead contacts
- Timetable of delivery expectations and responsibilities
- Schedule of Suppliers meetings and memberships
- Communications Plan from the Contract Manager to key stakeholders
- Contract Objectives
- Benefits Realisation Plan
- Mobilisation Plan / Contract entry with timeframes
- Key Performance Indicators / Management Information Reporting
- Contract Variation Process
- Escalation process / procedures for non-delivery
- Opportunities for Continuous Improvement / Service Improvement / Innovation
- Exit Plan

Data Protection

With regards to GDPR, departments should work with the Information Governance team to ensure that a Data Protection Information Assessment (DPIA) is completed. The department will then work with Procurement to ensure the outcomes of the DPIA are considered within the strategy, requirements and the contract. The contract manager is then responsible for ensuring that GDPR requirements are followed in line with the contract and any issues or incidents are raised with the Information Governance team.

The department should work with Procurement to determine the level of Cyber Security risk at procurement planning stage. This level of risk then informs the requirements to be incorporated into the contract. It is the contract manager and data asset owners responsibility to monitor conformance with requirements, including accreditations being up to date. Any issues should be raised with the ABUHB IT Department and the Procurement team.

3. Aims

The purpose of this document ensures that ABUHB staff understand their role in managing contracts on behalf of the organisation and to encourage a consistent approach across the organisation to contract management.

4. Objectives

To outline contract management principles and provide guidance to contract managers on their role in managing contracts

5. Scope

This policy relates to the purchase of all goods and services and therefore affects:

- All ABUHB staff with budget responsibility
- All ABUHB staff with contract management responsibility
- All Procurement & Finance Staff

Separate NHS Wales Shared Services Partnership -Procurement Services (NWSSP-PS) procedures are in place for tendering and contracting so are not covered in detail in this document. Please contact NWSSP-PS for advice and support.

6. Roles and Responsibilities

The Chief Executive of ABUHB is responsible for ensuring procurement procedures are in place.

The Director of Finance, Performance and Value is responsible for putting in place financial procedures to ensure that goods and services are duly authorised and comply with the Scheme of Delegation which sets out authority delegated by the ABUHB Executive Board.

NHS Wales Shared Services Partnership – Procurement Services are responsible for establishing tendering and contracting processes and procedures in line with best practice and legislation. They are also responsible for providing support and advice to ABUHB on the purchase of all goods and services where required.

ABUHB budget holders are responsible for contract management of the contracts which they use within their divisions. Procurement and finance teams will support contract management and can provide advice and training where required.

7. Contract Management in Aneurin Bevan

7.1 Contract Strategy

The ABUHB Procurement Team, in partnership with the nominated contract manager will develop a Contract Strategy for any procurement over £100k. For contract management, the strategy will serve as a reminder of key stakeholders involved during procurement, previous history of the contract, supply market analysis, risk management, sustainability, procurement route and a high-level plan for contract implementation and management.

7.1.1 Robust Terms & Conditions

NHS Wales operates on a set of standard Terms & Conditions which form part of the procurement documents to be issued and agreed with the successful supplier. Alongside the specification and tender response, terms and conditions are an agreement as to how the contract will operate. It is therefore important that contract managers have a working knowledge of the T&C's however, the Procurement and Legal & Risk team are able to support should any queries arise

7.1.2 Contract Award Recommendation Report

The ABUHB Procurement Team, in partnership with the nominated contract manager, will develop a Contract Award Recommendation Report for any procurement over £100k. This document summarises the procurement process and seeks approval for a contract to be awarded. From a contract management standpoint, it summarises the benefits of the proposed contract and any savings the contract is expected to deliver. Contract management is the process for then delivering these benefits.

7.1.3 Contract Management Plan

The ABUHB Procurement Team, in partnership with the nominated contract manager, will develop a Contract Management Plan. This is a key document in the move from the procurement process to contract implementation and management. The document details contract term, owners and their responsibilities, the level of contract management required, communication plans, contract objectives, mobilisation plan, performance management / governance, escalation, risks and exit plan.

7.1.4 Contract Performance Report

The contract manager should provide a performance report to procurement and relevant directors at agreed periods. This assists procurement in understanding what went well and any issues and can assist in the next iteration of the procurement. The Contract Performance Report should also include a risk register which is updated at regular intervals to be agreed in the contract management plan.

8. Resources

There are no financial or resource implications for the implementation of this document. There are a number of supporting documents and training resources which can be accessed by clicking the links below *(Links to be inserted once documents are live)*:

Contract Strategy
NHS Wales Standard Terms & Conditions
Contract Award Recommendation Report
Contract Management Plan
Procurement Policy and Financial Control Procedure

9. Training

Training is available for ABUHB nominated contract managers and is provided by Procurement and Finance Teams.

15. Audit

Contract Management in line with this policy is subject to internal audit.

16. Review

This document should be reviewed in 3 years from publication.