Audit, Risk & Assurance Committee

Thu 06 October 2022, 09:30 - 12:30

Microsoft Teams

Agenda

09:30 - 09:45
15 min

1. Preliminary Matters

1.1. Apologies for Absence

Verbal *Chair*

1.2. Declarations of Interest

Verbal *Chair*

1.3. Draft Minutes of the Meeting held on 02 August 2022

Attachment *Chair*

1.3 DRAFT ARA minutes 02.08.22 .pdf (10 pages)

1.4. Committee Action Log

Attachment *Chair*

1.4 Audit Committee Action Log - Oct.pdf (8 pages)

1.5. Committee Annual Programme of Business 2022/23

Attachment *Chair*

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

1.5.1. Assurance Note explaining the postponement of the Clinical Audit Plan

Attachment *Chair*

1.5a Audit Risk Assurance Committee - Assurance Note - Clinical Audit Plan .pdf (1 pages)

09:45 - 10:15
30 min

2. Corporate Governance, Risk and Assurance

2.1. To Receive an update on the Audit Recommendations Tracker at September 2022

To follow *Director of Corporate Governance*

2.2. To receive the Committee Risk Report

Attachment *Head of Risk & Assurance*

2.2 Strategic Risk Report Oct2022docx.pdf (5 pages)
2.2a Corporate Risk Regsiter OverviewSept2022.pdf (8 pages)
2.2b Final Master Risk Profiles Sept 2022.pdf (6 pages)

10:15 - 11:00
45 min

3. Financial Governance and Control

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

Attachment *Assistant Director of Finance, Corporate*

3.1 Single Tender Action Report - July - Spet 2022.pdf (3 pages)
3.1a Appendix 1 - STA July - Sept 2022 final.pdf (1 pages)

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

Attachment *Assistant Director of Finance, Corporate*

- Losses and Special Payments FCP
- Stores and Stocks FCP
- Summary Position on Financial Control Procedures

3.2 Finance Governance Report -06 October 2022.pdf (6 pages)
3.2a Appendix 1 ABUHB_Finance_0240 FCP Losses and Special Payments_Final.pdf (38 pages)
3.2b Appendix 2 ABUHB_Finance_0249 Stores and Stocks_Final.pdf (17 pages)
3.2c Appendix 3 - Financial Control Procedures .pdf (1 pages)

3.3. To Receive the Report of Losses and Special Payments

Attachment *Assistant Director of Finance, Corporate*

3.3 Losses and Special Payments Report (July 22).pdf (5 pages)

3.4. To Receive a summary report on Financial Accountability Arrangements

Attachment *Interim Director of Finance, Procurement & Value*

3.4 ARA Financial Accountability Arrangements 061022.pdf (7 pages)

11:00 - 11:20
20 min

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

4.1. To receive the Internal Audit Plan Progress Report

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

4.1 AB Internal Audit and Assurance Progress FINAL Report October 2022 ARA Committee.pdf (9 pages)

4.2. To Receive Final Audit Reports and Advisory Reviews

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

Substantial Assurance

- Grange University Hospital: Financial Assurance (Final Account)

Reasonable Assurance

- Children's Community Nursing Service Children & Young Peoples Continuing Care
- Job Evaluation Process

Advisory Review

- Agile Delivery

4.2b ABUHB_2223_GUH Final Account_Final Internal Audit Report.pdf (9 pages)
4.2 ABUHB 2022.23 CCC Internal FINAL Audit Report.pdf (20 pages)
4.2a ABUHB 2022-23 FINAL Job Evaluation Internal Audit Report for Client.pdf (13 pages)
4.2c AB 2223 FINAL Advisory Review Report -Agile Delivery v2.pdf (12 pages)

11:20 - 11:35
15 min

5. External Audit

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

Attachment *Performance Audit Manager, Audit Wales*

5.1 Audit Risk & Assurance Committee Update_Oct 2022.pdf (12 pages)

11:35 - 11:40
5 min

6. For Information – In Supporting Appendices

Verbal *Director of Corporate Governance*

- Audit Wales - Public Sector Readiness for Net Zero Carbon by 2030: Evidence Report *(Executive Lead Report scheduled for December)*
- Audit Wales - Continued COVID-19 response alongside growing patient demand keeps NHS funding growing as three health boards breach financial duties again
- Audit Wales - Continued COVID-19 response alongside growing patient demand keeps NHS funding growing as three health boards breach financial duties again

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11:40 - 11:40
0 min

7. Close of Meeting

Verbal *Chair*

Date of Next Meeting:

01 December 2022 - 09:30 – 12:30

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

Minutes of the Audit, Risk & Assurance Committee held on Tuesday 2nd August 2022 at 9.30 am via Teams

Present:	
Shelley Bosson	Independent Member (Chair)
Richard Clarke	Independent Member (Vice-Chair)
Paul Deneen	Independent Member
Katija Dew	Independent Member
Iwan Jones	**Independent Member (Finance)**
In attendance:	
Rani Mallison	Director of Corporate Governance
Rob Holcombe	Interim Director of Finance, Procurement & Value Based Healthcare
Mark Ross	Assistant Finance Director (Financial Systems & Services)
Danielle O'Leary	Head of Corporate Services, Risk and Assurance
Simon Cookson	Head of Internal Audit
Stephen Chaney	Deputy Head of Internal Audit
Andrew Doughton	Performance Audit Manager, Audit Wales
Nathan Couch	Performance Audit Lead, Audit Wales
Martyn Edwards	Head of Counter Fraud
Amanda Legge	Post Payment Verification Manager
Claire Snelling	Post Payment Verification Team Leader
Apologies:	
Glyn Jones	Interim Chief Executive
Tracey Veale	Finance Audit Lead, Audit Wales

	Preliminary Matters
AC 0208/01	**Apologies for Absence** The Chair welcomed everyone to the meeting. Apologies for absence were noted.
AC 0208/02	**Declarations of Interest** There were no Declarations of Interest to record.
AC 0208/03	**Draft Minutes of the Meeting held on 13th June 2022** The Committee accepted the minutes as a true and accurate reflection of the meeting.
AC 0208/04	**Action Sheet** The Committee reviewed the Action Sheet and was content that all completed actions could be removed.

	Action AC1306/04 Internal audit would request management to reframe the action response to be more explicit about IT involvement and to provide assurance that the system will be supported. **Action: Deputy Head of Internal Audit/Director of Planning**
	Corporate Governance, Risk and Assurance
AC 0208/05	**Committee Annual Programme of Business 2022/23** The Director of Corporate Governance (DofCG) presented the Committee work programme for 2022/23, which had been developed to ensure focus on the Committee's, core responsibilities as set out in Terms of Reference and the Audit Committee Handbook for Wales and NHS Wales. The Committee welcomed being able to view the Committee's work in a helpful, well-structured format, and noted that it would assist the Committee in monitoring and reviewing progress on key issues. The Committee thanked the DofCG for developing the revised Annual Business Programme 2022/23 and APPROVED the final version. It was AGREED that the Committee work programme would be added to each agenda as an item for information. **Action: Secretariat**
AC 0208/06	**Internal & External Audit Recommendation Tracker** The Committee received an update on the status of implementing internal and external audit recommendations since the Tracker was last presented to the Committee in March 2022. The committee was asked to review and approve the paper, which proposed a change to the original 'agreed-upon implementation' date for some internal and external audits, as well as some overdue recommendations. The tracker had been updated to include all audit reports presented to the Committee during the audit year 2021/22, which the Executive Team had reviewed and updated. The Committee was informed that an established process for tracking recommendations was in place, and it was recommended that the initial focus be on audit years prior to 2021/22. The Corporate Services Team would work closely with the Executive Team over the coming weeks to address the backlog of actions, and to clarify the time frames in which those would now be delivered, as well as acknowledging changing operational context. The Committee commended the work undertaken since March 2022 to provide a clear position in an accessible format; however, concerns were raised about the older recommendations, particularly the high-risk items. For those actions significantly overdue, it was requested that in reviewing and updating audit recommendations, the Executive Team consider the action to ensure it remains relevant within the current operating environment and the level of risk had not changed to that originally deemed by the audit team. The DofCG agreed to take this forward and with the Head of Risk & Assurance (HofR&A) identify opportunities to align audit recommendations to risk management systems in order that assurance could be taken on mitigating actions. The DofCG suggested a prioritised approach was taken for those actions significantly overdue and agreed to take this forward with the Executive Team in the next

	round of updates. **Action: Director of Corporate Governance/Head of Risk and Assurance** The Chair questioned the closed status recommendations, particularly Job Planning; she was not confident that all the recommendations had been covered sufficiently in detail. Similarly, some recommendations did not have any detail in the 'complete' column, which needed to be populated to provide assurance that the recommendations had been addressed. The Chair requested that the closed recommendations come back to the meeting in October with a summary of actions taken. In respect of the Job Planning actions specifically, it was agreed that an update on the Job Planning Audit would be requested from the Medical Director for presentation at a future meeting. **Action: Director of Corporate Governance** In response to the query, the DofCG proposed that where management had confirmed completion of all recommendations that arose from a limited rated assurance report, that a closure position report be presented to the Committee for greater assurance. wo. The Committee supported this approach for inclusion in the process for managing audit recommendations. Action: Director of Corporate Governance The Committee; - • NOTED the update and ongoing improvement work to ensure that the Audit Tracker accurately reflects the organisation's position.
AC 0208/07	**Review the Board Assurance Framework (BAF) 2022/23** A presentation on the BAF was given to the Committee, which facilitated a discussion about the Board's current understanding of the Health Board's assurance arrangements and the next steps in the ongoing development of an assurance system. The Committee was informed that an internal audit review of the BAF was conducted in March 2022, which received reasonable assurance in terms of being able to demonstrate that the Health Board had a BAF in place, but there were recommendations arising primarily around assessing the effectiveness of the assurances and having clear action plans in place where gaps were identified. The Chair advised that the Board had a reasonable level of understanding of the BAF, but there were concerns that it was directed at Board level and would not work in practice at an operational level. Further work was required to add depth to the framework to address this. Members of the Committee could not be assured that the current BAF was an effective assurance system as in some areas, 'no' gaps in assurance had been reported. The Committee suggested that a template would be useful so that Committees could clearly determine how their areas of responsibility and remit contributed to the broader BAF. This would also enable the identification and mapping of assurances, as well as the identification of gaps and the development of action plans to address any gaps that are identified. The DofCG acknowledged a lack of clarity, understanding, and ownership in how the BAF is used and owned, as well as a disparity between the BAF and the Corporate Risk Register (CRR). It was noted that there was an opportunity to bring the BAF and CRR together to have more informed

	discussions at the Board and through Committees, as well as shape the organisational system and encourage learning in relation to assurances and assurance gaps. To further understand the strategic risks that align with strategic priorities, it was proposed that a more layered approach to assurance was required. This would be a process-based course of action that enabled understanding of the system-wide internal control framework. A Board Briefing session on Risk & Assurance would be scheduled later in the financial year to assist with strengthening internal controls, governance, and accountability arrangements. **Action: Secretariat** The Committee questioned whether the team's resources and capacity were adequate to complete the proposed work programme and suggested that it be prioritised. The DofCG responded that as part of the 2021/22 Structured Assessment, Audit Wales had raised the need to review the Corporate Governance Team's capacity, and that resource proposals would be submitted by the end of the calendar year following an internal review of the current structure and capacity to inform any gaps and capacity requirements. The Committee NOTED the proposed revision to the BAF approach.
AC 0208/08	**Committee Risk Report (CRR)** The report was presented by the Head of Risk and Assurance (HofR&A), who outlined the key points and updates to the principal risks. There was also an update on the development of the Once for Wales (OfW) RL Datix Risk Management Module. It was noted that progress on the (OfW) Risk management module had reduced due to national group recommendations and amendments being applied to the draft system however, a progress update was expected in September 2022. The Committee was informed that a review of all Divisional risks captured through the Datix risk management system had been conducted, and that several 'themes' had been identified, resulting in the identification of 5 new risks and the reframing of 1 existing risk. These risks had been approved for inclusion in the CRR by the Executive Team and the Board. The Health Board reported 26 Organisational Risk Profiles, 17 of which were Principal Risks (scores of 15 or higher). Katija Dew, Independent Member (IM) raised questions in relation to the following risks: - • **CRR007** – Health Board strategy no longer fit for purpose to address the needs of a changing patient demographic **-** the descriptor referenced the Clinical Futures Model not taking into consideration the evolving needs of the population. The life course approach taken to develop and deliver the IMTP clearly supports the issues regarding changing patient demographics. The HofR&A agreed to review the risk in conjunction with the Executive Lead. **Action Head of Risk & Assurance/Director of Planning** • **CR0034** – Health Board response to Ukraine crisis- It was felt that the risk was much broader than what was described in the CRR and that

	the Board needed to be briefed on the full scope of the risk. The DofCG stated that a comprehensive assessment would be conducted and presented to the Board to ensure that the Board is aware of the full impact of the risk. It was noted that this risk should be considered in alignment with a further new risk that related to sustainability of Primary Care and impact due to repatriation of Ukrainian refugees. • **CR0027** – Effectiveness of COVID vaccination leading to variants of concern –Taking into consideration the Health Board position and success of the COVID vaccine programme and looking ahead to the winter, consideration was requested to broaden the risk to include seasonal vaccinations. Combining the immunisation programmes of the Health Boards into 1 (one) overarching principal risk would allow the Board to be sighted on all immunisation programmes. The HofR&A agreed to discuss if an overarching immunisation risk was required with the Executive lead. **Action: Head of Risk & Assurance/Director of Public Health and Partnerships** The DofCG stated that as part of the Board's risk and assurance development, a live demonstration of the new (OFW)RLDatix Risk Management Module would be arranged for a future development session to provide context for Committee members. **Action: Director of Corporate Governance/Head of Risk and Assurance** The Committee NOTED the report for ASSURANCE.
	Financial Governance and Control
AC 0208/09	Use of Single Tender Waivers and other Financial Governance Matters The Assistant Finance Director (AFD) provided an update on key accounting and governance issues and requested approval of the amendments to the Recovery of Overpayments to Employees and Budgetary Control Financial Procedures (FCP). The Committee was informed that, for the first time, the Health Board had fallen below the 95% target for public sector payments, but that this was primarily due to the volume of nurse agency invoices. The AFD stated that a plan was in place to restore compliance, but compliance may continue to decline as older payments are paid due to the metrics in place; however, this was not considered a long-term issue. The amendments to the Recovery of Overpayments to Employees FCP were noted as follows; - • Significant Overpayments – Payroll will notify Corporate Finance of the issue within 10 working days of confirmation (previously no deadlines were set). • Repayment of Debt and Repayment Terms – to agree a repayment plan, the employee is required to provide documented evidence of correspondence with a recognised debt support service (no documented evidence was previously required).

	• Payroll Query Process – employee to contact Payroll with query. Payroll to reply in a timely manner, no later than 10 days (previously no process documented). Budgetary Control FCP were noted as follows; - • Integrated Medium-Term Pan (IMTP) – reference to the Welsh Government's Citizen Centred Governance principles included • Budget Holders – responsibilities updated as per the revised Standing Orders (March 2021) wording • Changes to the Budget – clarification on Board notification and potential approval • Training – reference to the Finance Business Intelligence tool training included The Committee was assured that where overpayments had been made to employees, an appropriate and reasonable repayment plan that suited both the individual and the Health Board had been put in place. To provide additional assurance Members were informed that Workforce & OD had been tasked with developing mechanisms to refer employees to support services if they were affected by the cost-of-living crisis. Concerning the Budgetary Control FCP, the Committee queried what mechanisms were in place to hold individuals accountable where overspend was identified. The DoF explained that budgets were set in line with IMTP priorities and should be managed in line with the Budgetary Control Procedure. To ensure tighter control, a process was in place where a lower budget was set, and a tier system was in place for requesting budget extensions. The Chair acknowledged the response and requested that it be discussed in more detail at the People and Culture Committee in terms of performance reviews, as well as the Finance and Performance Committee in terms of financial performance. **Action: Secretariat** The DofCG noted that the Board had identified the need to understand the organisation's accountability framework in all aspects of business, but given the financial position there was an immediate focus needed on the financial accountability arrangements within the organisation. Further work was therefore needed to determine how the Executive holds the organisation accountable for financial performance and how the Board seeks assurance on those arrangements through the Committee structure. It was agreed that a progress report and an update on financial accountability arrangements would be presented at the next Committee meeting. **Action: Director of Finance, Procurement and IT & Director of Corporate Governance/Secretariat** The Committee took note of the Single Tender Actions (STAs) taken since the previous reporting period. The Chair queried ABU-STA-50110 the procurement of office furniture in respect of the narrative to explain the decision to award the contract. The ADF agreed to review the detail of the tender and inform Members electronically. **Action: Assistant Director of Finance** The Committee; -

	• ENDORSED the proposed changes to the financial control procedures • APPROVED the report.
	Anti-Fraud
AC 0208/10	**Quarterly Report on Counter Fraud Activity** The HofCF presented the quarterly report, noting that the team's staffing deficit was improving. Following a successful round of interviews, one accredited investigator was appointed, with a second round of interviews scheduled for the end of August 2022. Furthermore, succession planning had begun in advance of the current HofCF's retirement. The Committee was informed that criminal activity in cyber procurement and mandate fraud had increased. An embargo had been placed on an invoice received for £10 million for the supply of 1400 ITU beds, which the Health Board had not placed or received; and further embargoes had been placed on bank accounts and IP addresses. A risk assessment to better understand the threat would be carried out with the assistance of cyber security teams and Internal Audit, and it would be a key area of focus for the team. The DoF assured the Committee that robust internal controls were in place to prevent payments being made. Katija Dew, IM, was pleased to note the workforce returning to full complement, but she requested that any workforce capacity information be reviewed before publication due to the sensitive nature of the information. The Committee thanked the HofCF and team for their ongoing dedication to the preventative agenda. The Committee NOTED the Quarterly Report on Counter Fraud Activity for ASSURANCE.
AC 028/11	**Post Payment Verification (PPV) Annual Report** The Committee received the PPV Annual Report which highlighted how practices had been performing over the 2021/22 PPV cycle. It also demonstrated the Health Board's overall performance against national averages. The PPV Manager stated that due to the inability to conduct on-site visits during the three-year cycle, the review of PPV arrangements was undertaken remotely and focused on the General Medical services (GMS). Remote access via Microsoft Teams had begun with General Ophthalmic Services (GOS), with future visits planned for 2022-2023. Regarding Pharmacy Services (GPS) 2022, NHS Wales Shared Services Partnership (NWSSP) had introduced a pilot for two new service checks by PPV, which were the Quality and Safety Scheme and the Collaborative Working Scheme. These initiatives which would be rolled out across Wales once approved by the National Extended Services Management Board. The Committee was informed that PPV teams continue to meet with Counter Fraud nationally alongside individual Health Boards on a regular basis to discuss any issues that need to be investigated further, identify trends and promote cross-organisational learning. A new payment system for primary care services was implemented in April 2022, requiring evidence to be

	submitted alongside payment claims; this was noted as a valuable addition to try to reduce claim errors. The error rates against the GMSs statistics for the Health Board for 21/22 were lower than the All Wales average, but the revisits were higher due to one Practice with an error rate of 90.91% (100 claim errors against a sample size of 110). The Practice had received feedback, and the PPV Manager was optimistic that the next routine visit would show an improvement. The Committee NOTED the report for ASSURANCE.
	NWSSP Audit and Assurance – Internal Audit and Specialist Service Unit
AC 0208/12	**Internal Audit Plan Progress Update** The Committee was informed that there were two (2) outstanding reports from 2021/22, one of which, Waste Management, was on the agenda for noting. The 2022/23 Audit Plan position against progress was noted as one (1) in draft and six (6) in progress. The HofIA stated that the team had difficulty obtaining full management engagement with some of the operational audits, however work was taking place alongside the DofCG to address and move forward with the reviews. To avoid delaying reviews, work on other audits had commenced in order to provide balanced audit reporting to the Committee. The Committee offered its assistance to Internal Audit if it was required to ensure that all areas outlined within the scope of the 2022/23 Audit Plan engaged in the review process. The Committee; • NOTED the progress of the 2022/23 Internal Audit Plan • APPROVED the merger of the Access to Primary Care and Neighbourhood Care Networks audits
AC 0208/13	**Internal Audit Reviews (Reasonable)** The Committee received the Waste Management Audit Report and requested that management actions be assigned target dates before being included on the Audit Tracker; this was requested for all future reports. It was agreed that the DHofIA would contact the Capital Team to determine implementation/target dates for actions. **Action: Deputy Head of Internal Audit/ Director of Operations** The DofCG proposed developing a criterion to aid management in completing comprehensive management responses in conjunction with Internal Audit. **Action: Director of Corporate Governance / Deputy Head of Internal Audit** The Committee: - • RECEIVED the reasonable assurance report.
	External Audit
AC 0208/16	**Performance Update Report**

	The Performance Audit Manager (PAM), Audit Wales, presented the Performance Update report noting: • completed work, • work that had begun, • and planned work that had not yet begun. The Committee was informed that on June 172022, the Auditor General certified the Performance Report, Accountability Report, and Financial Statements, which were then laid before the Senedd. The audit of the Charitable Funds 2021-22 financial statements is scheduled to take place in the autumn, but dates had not yet been confirmed with the Finance Team. The Chair inquired as to when the Orthopaedic Follow Up Report would be released, noting that the Health Board had received a Getting It Right First Time (GIRFT) Report, which she hoped would be included in the report to ensure its relevance in the current operational context. Audit Wales responded that the publication date had not yet been confirmed but would likely to be October 2022, which would coincide with the Tackling the Planned Care Backlog National Report. The PAM also agreed to look at whether the GIRFT report could be reviewed, as the AW report was still in draft form. Following confirmation of the approach, the PAM would provide the Committee with a briefing note to confirm when the report would be published. **Action: Performance Audit Manager, Audit Wales** Iwan Jones, IM, queried the Staff Survey results appended to the Quality Governance report, noting that some of the responses were less than satisfactory and questioned where they would be reviewed and reflected on within the organisation. The DofCG advised that the findings of the Staff Surveys would be reviewed by the People and Culture Committee, and any actions would be approved in that forum. To reassure the Committee, the DofCG agreed to discuss the findings with Director of Workforce to triangulate the information and that the Patient Quality, Safety Outcomes (PQSO) Committee review of the Quality Assurance Framework would also address some of the key issues raised in the survey responses. **Action: Director of Corporate Governance** Paul Deneen, IM, inquired about the number of survey responses and how many staff responded from the Scheduled Care Division to determine the level of qualitative data. He is also asked where in the report was the methodology that supported the review. The DofCG informed the Committee that the approach and scope of the audit had the full support of the Clinical Executives, and that an action plan had been commissioned in response to the review, with oversight of the actions being reported to the PQSO Committee. It was agreed that the definitive numbers of staff in the Scheduled Care Division would be shared with Committee members outside of the meeting. **Action: Head of Risk and Assurance** The Committee NOTED the report for ASSURANCE.
AC 0208/17	**Audit Wales - Review of Quality Governance Arrangements**

	The Committee NOTED the Quality Governance Arrangements and ENDORSED the inclusion of recommendations on the Audit Tracker.
AC 0208/18	The Committee NOTED the following for information; - • Press Release 28/02/2022 - Audit Wales ambitious new five-year strategy 'Assure, Explain, Inspire' • Auditor General highlights that the Welsh Community Care Information System is at a critical phase • Tackling the planned care backlog in NHS Wales The DofCG recognised the Chair's contribution to the Committee and thanked her for her tenure, noting that this would be Shelley Bosson's final meeting as Chair of the Committee; Iwan Jones, Independent Member (Finance), would take over.
AC 0208/23	**Date of Next Meeting**
	The date of the next business meeting was noted as: - Tuesday 6th October 09:30 -12:30 via Microsoft Teams.

Audit, Risk & Assurance Committee
Action Sheet

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

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

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

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
February 2022	**AC 0302/07**	Produce an outcomes report outlining ways that the Health Board could streamline the termination/new starter process for managers.	D of FP&V H of CF	**06 Oct '22**	**Completed.** Counter Fraud have undertaken a full risk assessment and local proactive exercise on overpayments of salaries which includes termination (leavers) forms. This risk assessment was done in collaboration with Corporate Finance & Payroll Services from NHS Wales Shared Services Partnership and Intermal Audit.
June 2022	**AC 1306/04** Action Sheet	**1705/06 - The** management response to the Care After Death Audit be reviewed to ensure it appropriately captured the action required to procure an appropriate replacement software system that was fit for purpose	DHead of I A Director of Planning	**06 Oct '22**	**Completed.** The recommendations will be added to the IA Follow up cycle to ensure that they are properly addressed.
August 2022	**AC 0208/04** Action Sheet	**1705/06 -** Internal audit would request management to reframe the action response to be more explicit about IT involvement and to provide assurance that the system will be supported.			

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

June 2022	**AC 1306/05** Counter Fraud	Benchmark the Health Boards counter-fraud resources against those of other Health Boards.	D of FP&V	**06 Oct '22**	**Completed.** The 2021/22 all-Wales Counter Fraud performance report, disseminated on 18th August 2022 covers this off.
August 2022	**AC 0208/06** Internal & External Audit Recommendation Tracker	Take forward with the Executive Team whether the high-priority findings and high-risk areas are still relevant, if so a prioritised approach for the significantly overdue to be implemented. Identify opportunities to align audit recommendations to risk management systems in order that assurance could be taken on mitigating actions.	D of CG H of R&A	**06 Oct '22**	**Completed.** Included in the report to Committee 6th October.
August 2022	**AC 0208/07** Review the Board Assurance Framework (BAF) 2022/23	Schedule a Board Briefing session on Risk & Assurance later in the financial year to assist with strengthening internal controls, governance, and accountability arrangements.	Secretariat	**31 Aug '22**	**Completed.** Emailed Head of Governance to schedule

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

August 2022	**AC 0208/08** Committee Risk Report (CRR)	Review Risk CRR007 to ensure that it reflects the IMTP's life course approach, which was developed to support the evolving needs of the population and changes in patient demographics.	H of R&A Director of Planning	**6 Oct '22**	**Completed.** Changes reflected in the report to Committee 6th October.
August 2022	**AC 0208/08** Committee Risk Report (CRR)	Risk CR0027 - Discuss with the Executive Lead whether broadening the current risk to include seasonal vaccinations and having an overarching immunisation risk is appropriate.	H of R& A Director of Public Health and Strategic Partnerships	**06 Oct '22**	22.09.22 - Due to annual leave and other priorities this has yet to be deiscussed.
August 2022	**AC 0208/08** Committee Risk Report (CRR)	A live demonstration of the new (OFW)RLDatix Risk Management Module to be arranged for a future Board Development Session.	D of CG H of R&A	**31 Aug '22**	**Completed.** Emailed Head of Governance to schedule

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

August 2022	**AC 0208/09** Use of Single Tender Waivers and other Financial Governance Matters	Budgetary Control FCP - To be discussed further at the People and Culture Committee in terms of performance reviews, and the Finance and Performance Committee in terms of financial performance.	Secretariat	***31 Aug '22**	**Completed.** Emailed Secretariat
		A progress report and an update on financial accountability arrangements would be presented at the next Committee meeting.	D of CG D of FP&V Secretariat	**06 Oct '22**	**Completed.** Included in the report to Committee 6th October.
		Tender ABU-STA-50110 - Review the narrative explaining the contract award decision and notify Members electronically.	AD of F	***31 Aug '22**	**Completed.** The furniture and equipment for the wellness centre were purchased with funds from the 21/22 budgets. The Health Board's appointed supplier did not respond to this urgent request, and an alternative supplier, in this case, COS Group, was able to provide the required goods and agreed to hold the equipment until it was needed. As a result, a Single Tender Action was created and approved by Executives.

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

August 2022	**AC 0208/13** Internal Audit Reviews	Contact the Capital Team before adding recommendations to the Audit Tracker to determine implementation/target dates for actions.	DHead of I A Director of Operations	***31 Aug `22**	**Completed.** Target dates attributed.  AB%20Waste%20Management%20Audi
August 2022	**AC 0208/13** Internal Audit Reviews	Develop a criterion to aid management in completing comprehensive management responses	D of CG DH of IA	***31 Aug `22**	**In progress.** Best practice has been identified by the HofIA which will be used to create a one page reference guide.
August 2022	**AC 0208/16** Performance Update Report	Confirm whether the GIRFT report can be reviewed and included in the Orthopaedic Follow Up Report. Following confirmation of the approach, send the Committee a briefing note confirming the publication date of the Orthopaedic Follow Up report.	PAM AW	***31 Aug `22**	**Completed.** Email provided to the Chair on 23 August. AW will produce an all-Wales report. When the report is completed, AW recommends that it be read alongside the local GIRFT report to allow officers to respond to the AW report and provide an update on any early progress on the recommendations made in the GIRFT report. Before it can be received by the Committee, the AW report must be issued in draft form and cleared. The draft is expected to be released in September 2022.

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

		The Scheduled Care attitude survey findings regarding quality and patient safety arrangements to be discussed with the Director of Workforce & OD (D of WOD).	D of CG	***31 Aug `22**	**Completed.** Email sent to the D of WOD on 5th September.
		Share with Committee members the exact number of Scheduled Care Division employees in order to determine the level of qualitative data obtained from the targeted Staff Survey.	H of R&A	***05 Aug `22**	**Completed.** Email circulated to members on 03.08.2022

N.B. The actions denoted by a * had not been assigned a completion date. The dates assigned have been deemed adequate for completing the action.

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

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

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

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

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

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

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

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			7th April	17th May	13th June	2nd Aug	6th Oct	1st Dec	2nd Feb
Review of the Counter Fraud, Bribery and Corruption Policy	3-Yearly (2023)	Director of FPV							
Receive the Counter Fraud Annual Report	Annually	Head of CF		√					
Agree the Counter Fraud Annual Workplan	Annually	Head of CF		√					
Receive a Quarterly Report on Counter Fraud Activity	Quarterly	Head of CF				√		√	
Agree the Counter Fraud Functional Standard Return Declaration	Annually	Head of CF			√				
Receive the Post Payment Verification Annual Report	Annually	PPV Manager				√			
Agree the Post Payment Verification Annual Workplan	Annually	PPV Manager							
Receive a Mid-Year update in respect of Post-Payment Verification Activity	Bi-Annually	PPV Manager							
Clinical Audit									
Ratify the Clinical Audit Plan to be overseen by the PQSO Committee	Annually	Medical Director					X	Rescheduled √	
Receive an Annual Report on Clinical Audit Activity	Annually	Medical Director							√
Internal Audit (Including Specialised Audit) – NWSSP Audit & Assurance Services									
Agree the Internal Audit Annual Workplan	Annually	Head of Internal Audit			√				
Receive Internal Audit Progress Reports	Standing Item	Head of Internal Audit	√	√	√	√	√	√	√
Receive Internal Audit Review Reports, reviewing the adequacy of executive & management responses to any issues identified, ensuring that they are acted upon	As Scheduled within Annual Work plan	Head of Internal Audit Plan							
Review and approve Internal Audit terms of reference (charter) and the effectiveness of internal audit	Annually	Head of Internal Audit with Chair			√				
External Audit – Audit Wales									
Receive the External Audit Annual Audit Report	Annually	Audit Wales						√	
Agree the External Audit Annual Plan	Annually	Audit Wales		√					
Receive the 2022 Structured Assessment	Annually	Audit Wales						√	
Receive External Audit Progress Report 2021-22	Standing Item	Audit Wales	√	√		√	√	√	√

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			7th April	17th May	13th June	2nd Aug	6th Oct	1st Dec	2nd Feb
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	√					√	

Items Requested by Committee Members / Internal & External Stakeholders

Matter to be considered	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			7th April	17th May	13th June	2nd Aug	6th Oct	1st Dec	2nd Feb
Decarbonisation Update Report - Uncertainty that the ambition for a net zero public sector	Ad-hoc	Trish Chalk SRO for decarbonisation						√	
ABUHB approach to the COVID 19 Inquiry	Ad-hoc	D of CG						√	

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
√	Upcoming Meeting Agenda Items
√	Not received at scheduled meeting
√	Future meetings
√	Draft & Final Accounts

Aneurin Bevan University Health Board

Health Board Committee Assurance Note

Deferred Item	Clinical Audit Plan
Date scheduled on Forward Work Programme	6th October 2022
Proposed Date for deferment	1st December 2022
Executive Lead	Dr James Calvert, Medical Director
Reporting to:	Audit, Risk & Assurance Committee

Summary

I would like to extend my apologies for the ARA Committee in regards to the postponement of the Clinical Audit Plan.

The postponement has been requested as a result of both a new Director of Nursing, who has recently joined, and a new Assistant Director for Quality and Patient Safety, due to commence in October 2022.
Both the Director of Nursing and Assistant Director for Quality and Patient Safety hold a joint responsibility, with myself, for clinical audit and resulting quality and patient safety issues.

The clinical audit plan has been fully drafted but I require time to meet with both the Director of Nursing and Assistant Director for Quality and Patient Safety, following the commencement of the latter, to ensure that the plan meets their aspirations prior to submission.

I will endeavour to ensure the meetings are held with both individuals by the end of October, to enable any amendments to be made with time to submit the paper to the December committee.

I do not believe there are any performance, safety or reputational implications to the paper coming to the committee at a later date.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Audit, Risk and Assurance Committee 6th October 2022 Agenda Item: 2.2

Aneurin Bevan University Health Board

AUDIT, RISK AND ASSURANCE COMMITTEE - STRATEGIC RISK REPORT

Executive Summary

This report provides an overview of all **26** strategic risks described on the Corporate Risk Register.

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

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

The Committee is also requested to note at ***Appendix 3*** the update against the objectives set out within the Risk Management Strategy.

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

Executive Sponsor:	**Rani Mallison, Director of Corporate Governance**		
Report Author:	**Danielle O'Leary, Head of Corporate Services, Risk and Assurance**		
Report Received consideration and supported by :			
Executive Team	**X**	**Committee of the Board**	**Audit, Risk and Assurance Committee**
Date of the Report: 27th September 2022			
Supplementary Papers Attached: **Appendix 1 – Dashboard/Overview of Corporate Risk Register** **Appendix 2 – Committee Risk Assessments**			

Purpose of the Report

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

Background and Context

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

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

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

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

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

Assessment and Conclusion

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

The Risk Management Strategy and associated delivery approach was first endorsed by the Audit, Risk and Assurance Committee in August 2021, following which a benefits realisation plan was received and approved at the Committee in April 2022. The Committee is requested to review the progress update against the plan at ***Appendix 3;*** noting the areas of progress and areas that require further development.

The Risk Management Strategy continues to embed across the organisation. Evidence of this has recently been provided at the People and Culture Committee where risks relating to potential Industrial Action and increased reliance on agency usage were highlighted.

The Executive Team are due to consider a review of the Corporate Risk Register where the risks highlighted by the People and Culture Committee and a Safeguarding risk highlighted by the Corporate Nursing Department will be considered.

Current Organisational Risk Profile:
There are currently **26** Organisational Risk Profiles, of which **16** form Principal Risks due to the scoring being 15 or greater and are included within the Board Assurance Framework. The following table provides a breakdown of the risks and level of severity:

High	**16**
Moderate	**9**
Low	**1**

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

Changes in Risk Status Since Last Reporting Period

The Committee is requested to note that 4 risks on the Corporate Risk Register continue to be actively managed within an approved and agreed risks appetite/tolerance level, these are:
CRR023 – Avoidable harm to the population
CRR004 – WboFG Act and Socio-Economic Duty
CRR008 – Health Board estate being fit for purpose
CRR020 – WCCIS implementation

The *Finance and Performance Committee* have received a recommendation to de-escalate **CRR020 – WCCIS implementation risk**. This is on the basis that the platform has now been implemented across the organisation and local, project management of the risk will be enabled. An outcome on this recommendation is awaited and will be reflected in the next report to the Board in November 2022.

The Committee is also asked to note that despite the **CRR016 financial breakeven 2022/23** risk remaining at its previous score, the trajectory for this continues to escalate the position. Finance and Performance Committee will receive and request assurances in relation to the management of this risk and escalate to Audit, Risk and Assurance Committee as necessary.

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

Recommendation
The Committee is requested to: • **RECEIVE** updates outlined within the risk profiles. • **NOTE** the ongoing engagement with Executive Team in anticipation of further risks being proposed to be de-escalated and escalated to the Corporate Risk Register at the next Board meeting. • **NOTE** the update in relation to the benefits realisation plan associated with the Risk Management Strategy.

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

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

framed Jan 2022)								
CRR013 Failure to prevent and control hospital and community acquired infections to include COVID-19	10	10	**Zero or low** due to patient safety and quality of service.	**Yes**	**Treat** the potential impacts of the risk by using internal controls.	**(Sept 2022 Board)** 	**PQSO**	**Director of Nursing**
CRR020 Failure to implement WCCIS leading to inaccessibility of essential patient information. ***Recommended for de-escalation***	10	10	**High** level of appetite for risk in this area to innovate in the area of digital technologies. **Low** level risk appetite for the realisation of this risk and to maintain patient safety.	**Yes**	**Treat** the potential impacts of the risk by using internal controls.	**(Sept 2022 Board)** 	**FPC**	**Director of Planning, Performance and ICT**
CRR023 Potential risk to population health in relation to avoidable harm due to priority being given to management of the COVID pandemic.	20	20	**Zero or low** level of risk appetite in terms of protecting patient safety and the quality of services. **Moderate** level of risk appetite in relation to different ways of working to address backlog. This would include the use of technologies and innovations.	**Yes**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(Sept 2022 Board)** 	**PQSO**	**Director of Operations**
CRR007*re-framed July 2022* Clinical Futures model of care does not take into consideration the evolving needs of	16	12	**Zero or low** level of risk appetite in terms of protecting patient safety and the quality of services. **Moderate** level of risk appetite in relation to some risk controls and mitigations is required due to interdependencies with partner organisations.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work and	**(Sept 2022 Board)** 	**PPHPC**	**Director of Primary, Community and Mental Health Services & Director of Public Health and Strategic Partnerships**

the population at this time					some are out of the Health Board's control.			
CRR010 Inpatients may fall and cause injury to themselves.	15	10	**Zero or low** in the interests of patient safety.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Sept 2022 Board)** 	**PQSO**	**Director of Therapies and Health Science**
CRR027 Effectiveness of COVID vaccination and booster programme compromised leading to a Variant of Concern	25	20	**Moderate** risk appetite level will need to be applied to this risk profile, given the unpredictability of the potential of variants of concern. The Health Board will ensure that it can behave appropriately to address the risk, should it materialise however, emergence of a variant of concern is beyond the Health Board's control.	**No**	**Treat** the potential impact of the risk with mitigations. **Tolerate** the unpredictable element of the VoC and other mutations.	**(Sept 2022 Board)** 	**PQSO**	**Director of Public Health and Strategic Partnerships**
CRR028 Continued inappropriate admissions of Children and Young People to adult mental health in-patient beds.	20	10	**Low** risk appetite level in relation to patient safety and experience. **Moderate** level risk appetite would be encouraged in order to explore more innovative ways of managing this risk alongside Health Board partners.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Sept 2022 Board)** 	**PQSO**	**Director of Primary, Community and Mental Health Services**

CRR003 Mental Health services will fail to meet the anticipated increased demand of the Health Board population, for Mental Health support, in light of the COVID 19 pandemic.	12	8	**Low** risk appetite level in the interests of patient safety. **Moderate** risk appetite levels will need to be taken to explore further innovations and appropriately reconfigure services and implement new arrangements.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(Sept 2022 Board)** 	**PQSO**	**Director of Primary, Community and Mental Health Services**
CRR026 Risk to the general population and patients already within our services, due to less than adequate surge capacity to address any further exponential increase in pandemic response. ***links to Workforce risk – CRR002**	20	5	**Low** risk appetite level will be applied.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Sept 2022 Board)** 	**PQSO**	**Director of Operations**
CRR004 Failure to comply with WBoFG Act and Socio-Economic Duty	4	4	**Low to Moderate** - Risk appetite in this area is low in terms of compliance with the Legislation. However, further innovation is required to develop new approaches and ways of working therefore, risk appetite in this area is defined at a moderate level.	**Yes**	**Treat** the potential impacts of the risk by using internal controls. **Take Opportunities** and use positive risk management to realise efficiencies, better ways of working and realise our long-term strategic aims.	**(Sept 2022 Board)** 	**ARAC**	**Director of Public Health and Strategic Partnerships and Board Secretary**

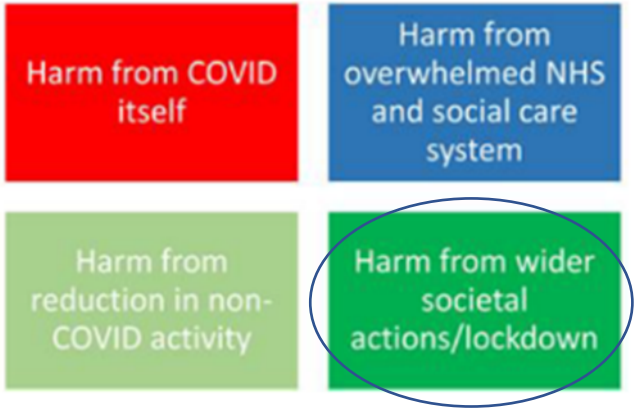
CRR017 Partial or full failure of ICT infrastructure and cyber security	15	12	**Low** appetite in relation to adverse impact on Quality, Safety. **Moderate to High** level risk appetite for innovating to identify digital ICT system solutions.		**Treat** the potential impacts of the risk by using internal controls.	**(Sept 2022 Board)** 	**FPC**	**Director of Planning, Performance and ICT**
CRR016 Achievement of Financial Balance	16	4	**Low** level of risk appetite in relation to the Health Board's financial statutory requirements. However, responding to COVID 19 implications and maintaining safe services take precedence.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Sept 2022 Board)** 	**FPC**	**Director of Finance and Procurement**
CRR012 Inability to address health inequalities across the population leading to increased dependency on Health Board services in the longer term and impacts ability of achievement of strategic aims/objectives. **(re-framed Dec 2021)**	12	4	**Low** risk appetite in terms of patient safety and services**.** **Moderate** risk appetite with regard to innovation and developments in primary care and public health initiatives.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Sept 2022 Board)** 	**PPHPC**	**Director of Public Health and Strategic Partnerships**
CRR008 Health Board Estate not fit for purpose (**Re-framed Dec 2021**)	15	15	**Low** risk appetite in relation to adverse staff and patient experience due to poor Health Board estate.	**Yes**	**Treat** the potential impacts of the risk by using internal controls and continue to maintain the current position	**(Sept 2022 Board)**	**FPC**	**Director of Operations**

			Moderate risk appetite with regard to innovation and developments across the Health Board estate.		with ongoing monitoring and review. ***Although this has reached its target score, it is recommended that this risk continues to be monitored strategically as the impact/consequence should the risk be realised, is significant.***			
CRR032 Failure to achieve underlying recurrent financial balance	16	12	**Low** level of risk appetite in relation to the Health Board's financial statutory requirements.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Sept 2022 Board)**	**FPC**	**Director of Finance and Procurement**
CRR033 (Dec 2021) Civil Contingencies Act Compliance	20	9	**Low** risk appetite in this area is low in terms of compliance with the Legislation.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Sept 2022 Board)**	**FPC**	**Director of Planning, Performance and ICT**
CRR021 Welsh Language Act Compliance	12	8	**Low** risk appetite in this area is low in terms of compliance with the Legislation.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Sept 2022 Board)**	**P&C**	**Director of Workforce and OD**
CRR025 Well Being of Staff and normalisation of risk	12	8	**Low** risk appetite in relation to adverse staff experience due to current and ongoing significant operational pressures.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Sept 2022 Board)**	**P&C**	**Director of Workforce and OD**

CRR034 (April 2022) Disruption to Health Board services due to the Ukraine crisis.	10	5	**Low** risk appetite in this area in respect of patient safety however, a **higher** risk appetite will need to be applied when reviewing regional responses to the crisis and how the Health Board and its Partners can work collectively to address and mitigate the risks.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Sept 2022 Board)** ⇔	**ARAC**	**Director of Planning, Performance and ICT**
CRR035 Sustainability of Primary Care Services due to increased demand, revised working patterns and continued response to Ukrainian refugee crisis.	12	8	**Low** risk appetite in this area in respect of patient safety however, a **higher** risk appetite will need to be applied when exploring new and innovative ways of providing Primary Care Services.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some contributing factors are outside of the Health Board's control.	**(Sept 2022 Board)** ⇔	**PPHPC**	**Director of Primary, Community and Mental Health Services**
CRR036 Inability to deliver components of the Health Board's strategy and key priorities where the involvement of key Partners is essential	12	8	**Low** risk appetite in this area in respect of patient safety however, a **higher** risk appetite will need to be applied when exploring new and innovative ways of working alongside key Partners and acknowledge that some controls and mitigations are outside of the Health Board control.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Sept 2022 Board)** ⇔	**PPHPC**	**Director of Planning, Performance and ICT.**
CRR037 Clinically unsafe and inappropriate inter-site patient transfers and into communities	15	5	**Low** risk appetite in this area in respect of patient safety.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Sept 2022 Board)** ⇔	**PQSO**	**Director of Operations**

CRR038 Increased levels of patient acuity presenting resulting in an inability to staff appropriately and provide acceptable levels of care in line with best practice and guidelines.	15	5	**Low** risk appetite in this area in respect of patient safety.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Sept 2022 Board)** 	**PQSO**	**Director of Nursing/Director of Operations**
CRR039 Delays in discharging medically fit patients partly due to delays in accessing packages of care from Partners - ***covered in part by CRR019 on CRR (unmet demand and ambulance delays)***	20	10	**Low** risk appetite in this area in respect of patient safety however, a **higher** risk appetite will need to be applied when exploring new and innovative ways of working alongside key Partners and acknowledge that some controls and mitigations are outside of the Health Board control.		**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some contributing factors are outside of the Health Board's control.	**(Sept 2022 Board)** 	**PQSO**	**Director of Operations and Director of Primary, Community and Mental Health Services.**

<table>
<tr><td colspan="2">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</td><td colspan="4">Risk Description, Appetite and Decision</td></tr>
<tr><td colspan="2" rowspan="2">• This is an enabler risk and therefore impacts the Health Board's ability to achieve all objectives and strategic priorities</td><td colspan="4">CRR034 *this risk should be considered in conjunction with the new primary care sustainability risk*
Risk of disruption of provision of Health Board services
Due to the ongoing Ukraine crisis.</td></tr>
<tr><td colspan="4">Impact
Potential workforce, resource and financial implications in responding to the crisis and fulfilling expectations of Welsh Government due to the country being a 'super sponsor'.</td></tr>
<tr><td>High Level Themes</td><td>• Partnership
• Quality and Patient Safety
• Patient Outcomes and Experience
• Finance
• Public Confidence
• Reputational</td><td colspan="2">Risk Appetite</td><td colspan="2">Low (averse to risk)
Risk Appetite
Level 2</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="4">Risk Score</td></tr>
<tr><td>Audit, Risk and Assurance Committee</td><td>• Service Business Continuity Plans (BCPs)
• Service Contingency Plans
• Internal demand modelling data related to numbers of refugees incoming to the Health Board area.
• Welsh Government guidance on healthcare provision for asylum seekers/refugees.
• Internal bi-weekly meetings convened to report directly to Executive Team with</td><td>Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td>Current Risk level after initial controls/mitigations have been implemented.</td><td colspan="2">Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
</table>

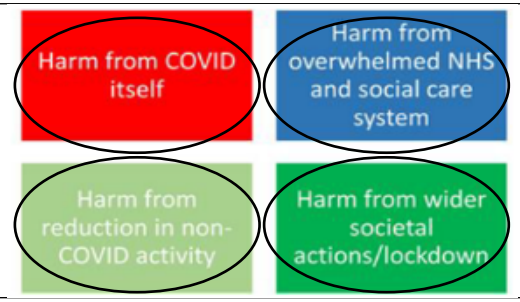
	escalations and by exception.							
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***		**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
			3	5	2	5	1	5
Conduct analysis of Business Continuity Plans across sites and Divisions to ensure a state of readiness and ensure that this is communicated with key individuals across the organisation. Review and testing of Health Board Civil Contingencies Plans. Workforce colleagues identify and ensure support for staff who have family or friends in the Ukraine or Russia. Regular National engagement on the conflict and regular, collective impact assessments undertaken alongside Welsh Government.		Ongoing Ongoing Ongoing Ongoing	**15**		**10**		**5**	
Trend			**Executive Owner: Interim Director of Planning and Performance**					
Mapping Against 4 Harms of COVID			**Update**					
			Sept 2022 A focus group has been established to meet monthly to discuss any potential risks as the crisis develops. This group will report to Executive Team by exception as and when required. The Community and Primary Care Division group meets weekly relating to the refugee workstream. A clear governance structure from Welsh Government has not been agreed however, it is anticipated that it will likely report to the regional Public Service Board (PSB). Structures in place for different aspects of the resettlement sponsorship schemes. Each Local Authority managing the process in their Borough the Health Board work with and across the Local Authority areas. Governance routes already established consist of: • Health Board Cyber security team liaise with the NCSC • Business Continuity into the Tactical Business Continuity Group. Health Board representatives from Emergency Planning Team and the Head of Risk and Assurance form part of the membership of the Gwent Tactical Local Resilience Forum where this				

	specific risk is discussed with Partners. Opportunities for internal escalation are established with Head of Civil Contingencies reporting to Executive Team. The sponsorship routes have supported increasing numbers of refugees, with visas issued to support relocation to Wales. Each LA have been asked to identify suitable venues for refugee housing. There are 2 Welcome centres in the Gwent area, the use of Hotels across Boroughs, and refugees housed with families. The Health Board provides Health Assessment and screening for all refugees within agreed timeframes prior to individuals being registered with a General Practitioner in the local area.

<table>
<tr><td>Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</td><td colspan="3">Risk Description, Appetite and Decision</td></tr>
<tr><td rowspan="2">Getting it right for children and young adults
Supporting adults in Gwent to live healthy and age well
Provide high quality care and support for older adults
Staying healthy
Care closer to home
Less serious illness which require hospital care</td><td colspan="3">CRR004 (Nov 2021) – (Reframed)
Risk of Non-compliance with relevant Legislative requirements.
Due to The Health Board does not meet its statutory duty under the Well-Being of Future Generations (Wales) Act 2015 or the Socio-Economic Duty.

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

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

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

Audit, Risk & Assurance Committee

Update on Single Quotation and Tender Actions – 1st July 2022 to 12th Sept 2022

Executive Summary
This report gives the Audit, Risk and Assurance Committee an update in relation to the number and value of Single Quotations / Tenders that have been submitted in the period 1st July 2021 to 12th Sept 2022 in accordance with the Committee's terms or reference and workplan. The Audit, Risk and Assurance Committee is requested to • Note the contents of this report.

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

Executive Sponsor: Rob Holcombe – Director of Finance, Procurement and Value Based Healthcare			
Report Author: Rob Type – Deputy Head of Procurement			
Report Received consideration and supported by: NA			
Executive Team		**Committee of the Board [Audit, Risk and Assurance Committee]**	
Date of the Report: 12th Sept 2022			
Supplementary Papers Attached: **Appendix 1 – Summary of Single Quotation / Tender Actions**			

Purpose of the Report

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

Appendix A provides specific detail regarding the Single Quotations / Actions that have been submitted and approved for the period 1st July 2021 to 12th Sept 2022.

Background and Context

It is a requirement of Aneurin Bevan Health Board Standing Orders and Standing Financial Instructions that all requests for a Single Tender action or a Single Quotation action are submitted to the Chief Executive for consideration. The 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.

Assessment and Conclusion

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 3 requests submitted which have been approved during the period with an annual value of £120,579.63 Ex VAT.

Of these 3 approved requests, all were classified as either licensing or maintenance/ service type arrangements, the scope of which could cover the on-going servicing / support of medical equipment, ICT Hardware/Software, or general licensing. There were not any classified as goods purchased.

Recommendation

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

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	*SFI's. SO's, Financial controls and accounting systems and processes form the basis of many organisational controls without which the organisation would be exposed to significant financial and reputational risk.*
Financial Assessment	*No direct financial implications but the financial governance issues covered in this standard Audit Committee paper set a framework of key financial controls for the organisation.*

Quality, Safety and Patient Experience Assessment	*Not applicable*
Equality and Diversity Impact Assessment (including child impact assessment)	*No adverse impact*
Health and Care Standards	*Not applicable*
Link to Integrated Medium Term Plan/Corporate Objectives	*SFIs, SOs, Financial controls and accounting systems and processes form the basis of many organisational controls which form part of the delivery of financial targets and good governance.*
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*Not relevant*
Glossary of New Terms	*Not applicable*

Appendix A - Summary of Single Tender/Quotation Actions

Date of Request	Type of Request	Reference No	Description	Anticipated Annual Value (ex VAT)	Supplier	Type	Reason for request	Advice from Procurement	Approved / Rejected	CEO Approval Date	Chairs Approval Date (If Applicable)
23/06/2022	Single Tender Request	ABU-STA-50777	Translation Services	£30,000.00	BLA Translation Ltd	Services	Work to be carried out to supplement main outsourced work when required as to lack of capacity. Cost of work is comparable to other outsourcers so this allows continuity across HB. Long term plans involve a change in SLA with ultimate goal of internal translation.	Approved in line with SFI's as there is a need to retain a particular contractor for continuity of service	Approved	08/07/2022	
20/08/2022	Single Tender Request	ABU-STA-51148	ACT Training	£83,000.00	Associated Community Training (C&V College)	Services	HEIW have agreed funding for our HCSW education programme, and specifically monies relating to delivery of the All Wales induction which ACT have been delivering for ABUHB. ABUHB are seeking an extension of work ACT have been delivering for the past two years to deliver a rich and meaningful induction and development programme for our Health care support workers - a new re-procurement exercise is in progress as its been delayed by COVID19	Appropriate as work is a continuation of a service that was tendered in 19/20 — this bridging arrangement will support the review of the service and the re-tender in 2022	Approved	26/08/2022	
23/08/2022	Single Quotation Action	ABU-SQA-51129	Saacke Combustion Services Ltd - Boiler Repair for RGH	£7,579.63	Saacke Combustion Services	Services	The repair work that is required to be completed is vital to enable a key part of the steam boiler system in the Royal Gwent Hospital to continue to work efficiently. The boiler is a specialist piece of equipment and the repairs are required to be completed by the manufacturer of the boiler, Saacke Combustion Services Ltd.	Approved in line with SFI's as there is a need to retain a particular contractor for continuity and cost.	Approved	25/08/2022	

Audit, Risk & Assurance Committee

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

Executive Summary

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

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

The Audit, Risk and Assurance Committee is requested to:

- Note the contents of this report.

- Approve the amendments to the following financial control procedures:
  - Losses & Special Payments
  - Stores & Stocks

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

Executive Sponsor: Robert Holcombe, Interim Director of Finance, Procurement and Value Based HealthCare			
Report Author: Estelle Evans, Head of Financial Services and Accounting			
Report Received consideration and supported by:			
Executive Team		**Committee of the Board**	**Audit, Risk and Assurance Committee**
Date of the Report: 20 September 2022			
Supplementary Papers Attached: **Appendix 1 – Losses & Special Payments Financial Control Procedure** **Appendix 2 – Stocks and Stores Financial Control Procedure**			

Appendix 3 – Financial Control Procedures Status

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

Assessment and Conclusion

1. Financial Control Procedures (FCP)

The FCPs to be reviewed at this Committee as part of the regular programme of updates are below. The renewal schedule is stated in Appendix 3. The procedures are:

- Losses & Special Payments
- Stock and Stores

The above FCPs were approved by the Executive Team on the 15 September 2022.

The Capital Assets and Charges and Engaging Off Payroll Workers will be presented at the December meeting.

A summary of the main changes is set out in section 2.1 and 2.2 below. The full revised FCP's are included as Appendix 1 and 2, with the changes highlighted yellow for ease of reference.

1.1 Losses & Special Payments

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

The procedure sets out the delegation limits for losses and special payments detailing how payments are approved, accounted for, and reported within the organisation.

Losses and special payments are items that Welsh Government (WG) would not have contemplated when it agreed funds for the Health Service or passed legislation. By their very nature they are items that ideally should not arise. They are, therefore, subject to a special Financial Control Procedure compared with the generality of payments.

The changes to the documents are mainly for clarification, update to Welsh Government guidance and organisational responsibility.

The document has been circulated for comment as follows:

- Director of Finance
- Assistant Directors of Finance
- Assistant Head of Financial Services
- Head of Financial Services and Accounting
- Head of Legal Services
- NWSSP-Audit and Assurance Services

Main changes to the document

Paragraph	Summary of change
All	Director of Finance changed to 'Director of Finance, Procurement and Value'
All	Audit Committee changed to 'Audit, Risk and Assurance Committee'
All	Intranet links added for internal documents
5.3	Scope - Medical Negligence - category clarified as 'including redress and general medical practitioners' indemnity
7.2	Delegated Limits - reference to the Litigation Committee reviewing settlements >100k added
9.1	Clinical Negligence & Personal Injury – payments clarified as follows: • Clinical negligence and personal injury costs <£25k liable by the Health Board • Clinical negligence and personal injury costs >£25k reimbursed by the Welsh Risk Pool • Redress payments for settlements and medical expert fees fully reimbursed by the Welsh Risk Pool
9.6	Approval of Payments - Bad Debts and claims abandoned. Procedure brought into line with the revised write off process previously approved by the Audit Committee
Appendix 2	Medical Negligence – 'including redress' added 'General medical practitioners' indemnity' - payments process added to flow chart Bad Debts – new procedure for bad debt write off included (write off limits; final review by; authorised by; payment details)

2.2 Stocks & Stores

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

The procedure specifies the controls needed for all items put in to stores and those treated as stock.

The procedure provides detailed guidance and direction for those employees with direct responsibility for the requisitioning and issuing of stores and stock items to mitigate the risk of loss or potential fraud within the Health Board.

The procedure identifies the requirements for recording and accounting for items and clarifies the distinction between items classified as stores and stock.

The document has been circulated for comment as follows:

- Director of Finance
- Assistant Directors of Finance
- CMA Finance Manager
- Estates Managers
- Procurement Services
- Head of Pharmacy
- NWSSP-Audit and Assurance Services

Main changes to the document

Paragraph	Summary of change
All	Reference to 'Theatres' added to Pharmacy and Works and Estates as a stock holding area
All	Director of Finance changed to Director of Finance, Procurement and Value
All	Intranet links added for internal documents
8.7	Stocktaking – reference to Automated Data Capture (ADC) and Omnicell added as stock systems/methods deployed across ABUHB
9	Accounting for Stores and Stocks updated to reflect revised roles and responsibilities within finance.
15	Glossary added
Appendix 1	Controlled and Non-Controlled Stores Stock Take Example of email sent to Managers – updated to reflect the revised roles within the finance team. Guidance Stocktaking Process – responsibility to also count and report Consignment Stock (to be recorded separately from ABUHB stock) added. A reporting requirement in the annual accounts.

2. Technical Accounting Issues

There are no new technical accounting issues to report to the Committee.

3. Public Sector Payment Policy (PSPP)

The following table shows the Public Sector Payment Policy performance for the month of August. The Health Board has achieved the target to pay 95% of the number of Non-NHS creditors within 30 days of delivery of goods in August. Although the cumulative performance remains below 95%, this is a significant improvement on previous months and reflects the work and support for the Resource Bank in particular, referred to in the previous report.

Category	Invoices	In Mth %	YTD %
NHS	Value Number	88.5 86.3	95.5 87.4
Non NHS	Value Number	91.6 96.6	94.6 94.5

5. Payments in Excess of £100K

There were no exceptional issues to report.

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

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	*SFI's. SO's, Financial controls and accounting systems and processes form the basis of many organisational controls without which the organisation would be exposed to significant financial and reputational risk.*
Financial Assessment	*No direct financial implications but the financial governance issues covered in this standard Audit Committee paper set a framework of key financial controls for the organisation.*
Quality, Safety and Patient Experience Assessment	*Not applicable*
Equality and Diversity Impact Assessment	*No adverse impact*

(including child impact assessment)	
Health and Care Standards	*No applicable*
Link to Integrated Medium Term Plan/Corporate Objectives	*SFIs, SOs, Financial controls and accounting systems and processes form the basis of many organisational controls which form part of the delivery of financial targets and good governance.*
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*Not relevant*
Glossary of New Terms	*FCP – Financial Control Procedure* *SFIs - Standing Financial Instructions* *SOs - Standing Orders* *NWSSP - NHS Wales Shared Services Partnership*

Aneurin Bevan University Health Board

Financial Control Procedure Losses and Special Payments

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

Status: DRAFT
Approved by: Audit Committee
Owner: Director of Finance

Issue date:
Review by date:
Policy Number: ABUHB/Finance/0240

Contents:

1. Introduction

This procedure sets out the delegation limits for losses and special payments detailing how payments are approved, accounted for and reported within the organisation.

2. Policy Statement

Losses and special payments are items that Welsh Government (WG) would not have contemplated when it agreed funds for the health service or passed legislation. By their very nature they are items that ideally should not arise. They are, therefore, subject to a special Financial Control Procedure compared with the generality of payments.

3. Aims

To ensure that all Health Board employees are aware of the reporting requirements in relation to Medical Negligence and Personal injury incidents and all other minor losses incurred within ABUHB.

4. Objectives

This document sets out the process to be adhered to within the Health Board when reporting a loss to the organisation to ensure:

- Staff have a clear understanding of their responsibilities with regards to the security of ABUHB assets.
- Losses and special payments are recorded when identified.
- Payments are approved that constitute a loss (e.g. clinical injury compensation payments).
- Losses are reported in the Health Board.
- Accounting arrangements.

5. Scope

5.1 All ABUHB employees have a general responsibility for the security of Health Board property and for minimising the risk of loss. Divisional directors have additional responsibilities for the security of patient's property and monies where it has been deposited for safe custody in accordance with the Patient's Property Financial Control Procedure.

5.2 All employees have a responsibility to report a loss to their manager. Managers have a responsibility to notify the Health Board in writing of all losses using the documentation outlined in this procedure.

5.3 Much of this Financial Control Procedure is drawn from guidance issued in the Welsh Government IFRS NHS Wales Manual for

Accounts. This procedure covers all losses which are described in this policy over the following categories:

- Medical Negligence (including Redress and General Medical Practitioners Indemnity)
- Personal Injury
- Ombudsman Claims
- Minor losses
  - Category 1 - Loss of Cash
  - Category 2 - Fruitless payments
  - Category 3 - Bad debts and claims abandoned
  - Category 4- Damage to buildings
  - Stock discrepancies and losses
  - Fraud
  - Special Payments

5.4 This policy should be read in conjunction with:

- IFRS Wales Manual for Accounts – Chapter 6 – Losses and Special payments
- Standing Orders
- Standing Financial Instructions

6. Roles and Responsibilities

6.1 The Director of Finance, Procurement and Value is responsible for:

- Ensuring the appropriate systems are in place to record losses and special payments.
- Ensuring appropriate systems are in place to enable losses and special payments to be accounted for properly and reported to the Board and Welsh Government.
- Ensuring the ABUHB has a nominated and trained Local Counter Fraud Specialist and that cases of fraud, misappropriation or other financial irregularities are investigated. The Counter Fraud Bribery and Corruption Policy sets out detailed procedures for dealing with fraud.

6.2 The Medical Director is responsible for the processing of claims for medical negligence, personal injury, loss of patient belongings and other patient related losses.

6.3 All ABUHB staff are responsible for:

- Proper security of ABUHB property and for the avoidance of loss.
- Notifying their line manager of all losses and potential losses.

6.4 Notifying the ABUHB Local Counter Fraud Specialist if a fraud bribery or corruption is discovered or suspected. General Managers and Directors must ensure that processes are in place to ensure the security of patient's property where it has been handed in to the ABUHB staff for safe keeping in line with the Patient's Property Financial Control Procedure.

6.5 All Managers are responsible for reporting all losses, using the appropriate documentation outlined in this procedure.

7. Delegated Limits

7.1 Losses and special payments above the limits delegated to the ABUHB shown in Appendix 1, must be submitted to Welsh Government for approval prior to any special payment or write off being made. The responsibility for submitting details of the loss to the WG is shown in Appendix 1 depending on the category of loss.

7.2 The delegation limits for Losses and Special payments in ABUHB are shown in the following table and in the HB Scheme of delegation.

	Clinical Negligence/Personal Injury		Redress	
	Settlements	**Legal Fees**	**Settlements**	**Legal Fees**
>£1,000,000	Welsh Government and Board	Welsh Government and Board	N/A	N/A
>£100,000<£1,000,000	Board	Board	N/A	N/A
>£25,000<£100,000	CEO	CEO	CEO	N/A
>£10,000<£25,000	Head of Legal Services	Head of Legal Services	Head of Legal Services	Head of Legal Services
<£10,000	Head of Legal Services	Claims Manager	Head of Legal Services	Claims Manager

Settlements over £100k are reviewed by the Litigation Committee (A sub-committee of the Board)

Ombudsman Claims	Per normal Scheme of Delegation approval limits.

Approvals of Losses & Special payments			
Category	**<£10**	**Up to delegated limit (see appendix 1)**	**Over Delegated limit**
Category 1 – Loss of Cash	n/a	Claims & Litigation sub-group	Welsh Government
Category 2 – Fruitless Payments	n/a	As per scheme of delegation	Welsh Government
Category 3 – Bad debts and claims abandoned	AFD	Audit, Risk and Assurance Committee	Welsh Government
Category 4 – Damage to buildings	n/a	As per scheme of delegation	Welsh Government
Category 5 – Compensation payments made under legal obligation	n/a	As per table in section 7.2 above in line with scheme of delegation	Welsh Government
Category 6 – Extra contractual payments to contractors	n/a	As per scheme of delegation	Welsh Government
Category 7 – Ex gratia payments	n/a	Head of Legal Services	Welsh Government
Category 8 – Extra statutory, extra regulatory payments	n/a	n/a*	Welsh Government

***** The Health Board has no delegated limit.

All losses irrespective of value are reported to the Audit, Risk and Assurance Committee.

8. Reporting Incidents of Loss and Potential Loss

8.1 Any member of staff identifying a potential loss shall report the incident details to their Head of Department who will immediately take action to recover the loss if possible. The circumstances in which the loss arose should be investigated and where necessary tighter controls put in place.

8.2 In the case of losses arising from clinical negligence or personal injury the Policy for the Management of Clinical Negligence and Personal Injury Litigation should be referred to.

8.3 The Head of Department must complete the relevant losses form from the Appendices to this policy and forward it to the address set out on the form. The police must be contacted as appropriate.

8.4 All details relating to the "write-off" will then be forwarded to the Assistant Director of Finance - Financial Systems and Services (or their representative) who shall enter the details in the ABUHB Losses and Special Payments Register (LaSPaR).

8.5 In the case of fraud or suspected fraud, the Head of Counter Fraud will seek authorisation to prosecute from the Director of Finance, Procurement and Value once the enquiry has been completed. The Counter Fraud, Bribery and Corruption Policy should be referred to for all suspected cases of fraud.

8.6 It is the responsibility of individual employees to safeguard public funds and resources and to report fraud or suspicion of fraud directly to the Local Counter Fraud Specialist.

8.7 Cases of overpayment of salaries and wages are subject to the Recovery of Overpayment to Employees Policy.

9. Approval of Payments

Appendix 2 shows the approval processes in diagram form for all losses. This section describes the process for each category of loss in detail.

9.1 Clinical Negligence & Personal Injury

The process for approving payments in cases of clinical negligence and personal injury is described in *the* Policy for Management of Clinical Negligence and Personal Injury Litigation. All payments are subject to the delegated limits set out in section 7 above.

Where concerns are pursued and the possibility of a qualifying liability is identified, confirmation of such is through the Redress Panel. Where these cases are expected to settle for less than £25K they are subject to the WG 'Putting Things Right' framework. These cases are considered through the Redress Panel but are still subject to the delegated limits set out in section 7 above. Where cases are received as a medical negligence or personal injury claim they are investigated as a claim regardless of the value in line with the Policy for the Management of Clinical Negligence and Personal Injury Litigation.

The budget and costs for clinical negligence and personal injury costs are held by the Medical Director. The Health Board are liable for the first £25k with any expenditure over £25k being reimbursed by the Welsh Risk Pool.

Redress payments for settlements and medical expert fees are fully reimbursed by the Welsh Risk Pool as and when incurred by the Health Board.

9.2 Ombudsman Cases

Where the Ombudsman makes a recommendation to make a compensation payment the payment is approved by and charged to the appropriate divisional or locality budget.

9.3 Other Losses

Other losses may include theft, fraud, arson, and sabotage, neglect of duty or gross carelessness.

9.4 Category 1 – Losses of Cash

(a) Overpayments of salaries, wages, fees or allowances.
Other causes including un-vouched or incompletely vouched payments, overpayments other than those in (b) above, physical losses of cash and cash equivalents such as stamps caused by fire, accident or similar causes.

Staff identifying any loss should immediately report this to their senior manager.

In all of the above cases a "loss of cash" form, attached in Appendix 3, must be completed by the manager of the department that incurred the loss. The form must then be submitted to the relevant department as identified on the bottom of the form for processing.

9.5 Category 2 – Fruitless payments, including abandoned capital schemes and constructive losses.

These are defined as payments that a potential recipient is legally entitled to even though the ABUHB will receive nothing in return. Examples are:

(a) Forfeiture under contracts as a result of error or negligence by the ABUHB.
(b) Payment for travel or hotel accommodation wrongly booked, or for goods or services incorrectly ordered or accepted.
(c) The cost of rectifying design faults due to lack of diligence or defective professional practices.

(d) Payment for bank charges incurred by ABUHB employees as a result of late payment of wages where it has been proven that the Health Board is at fault (Appendix 4)

In all cases there must have been an element of blame by a member of ABUHB staff.

Many degrees of error might be involved. The criterion is not whether the error is considered serious enough to warrant disciplinary action but simply whether the ABUHB was at fault in incurring, or not avoiding, the liability to make the payment.

As fruitless payments will be legally due to the recipient they are not regarded as special payments. However, as due benefit will not have been received in return, they should be regarded as losses.

In relation to capital schemes, the delegated limit from WG to the HB is £250,000.

A written report must be completed for all incidents and sent to the Director of Finance, Procurement and Value so that appropriate action can be taken.

9.6 Category 3: Bad Debts and claims abandoned

Bad debts and claims abandoned should be entered in the losses register when it has been determined that the loss is irrecoverable.

Bad debts can only be written off when all reasonable action has been taken to recover the debt.

Debts must be approved for write off by the Audit, Risk and Assurance Committee.

The Audit, Risk and Assurance Committee has given Delegated Authority for write-offs, depending on the value of the Bad Debt. Each debt will be fully reviewed by the responsible officers, before being presented for approval for write-off by the delegated authority. The below table sets out the Delegated Authority levels.

DELEGATED AUTHORITY LEVEL	From £	To £
Assistant Head of Financial Services	-	10
Head of Financial Services & Accounting	10	50
Assistant Director of Finance (Financial Systems & Services)	50	2,500
Director of Finance & Performance	2,500	25,000
Audit, Risk & Assurance Committee	25,000	50,000
Welsh Government	50,000	-

Any such loss written off will be charged to the originating budget.

9.7 Category 4 - Damage to buildings, including fittings, furniture, equipment and loss of equipment and property in stores and in use

Examples of this are:

(a) Culpable causes e.g. theft, fraud, arson or sabotage, neglect of duty or gross carelessness
(b) Losses by fire (other than arson)
(c) Losses by weather damage or accident
(d) Losses due to deterioration in use or deterioration in store due to defects in administration such as over-provisioning or obsolescence.

In all of the above cases a "report of loss" form, attached in Appendix 5, must be completed by the manager of the department that incurred the loss. The form must then be submitted to the Assistant Director of Finance – Financial Systems and Services.

9.8 Stock discrepancies and losses

If stock becomes obsolete the responsible department must notify the Assistant Director of Finance – Financial Systems and Services in writing so that arrangements can be made for it to be written off.

A stock take of all items will be taken at year-end in accordance with the Stocks and Stores procedure. All losses arising and their value should be clearly identified on the stock taking sheets which are completed on an annual basis. Any loss due to obsolete stock incurred during the year should be formally notified to the Assistant Director of Finance – Financial Systems and Services, in writing so that the appropriate action can be taken. All obsolete stock losses are recorded on the Losses and Special Payments Register

10 Fraud, Bribery and Corruption

All suspected cases of Fraud, Bribery and Corruption within the Health Board must be reported immediately and in accordance with the Counter Fraud, Bribery and Corruption Policy.

11 Special Payments

Claims for compensation fall into one of the following three classifications:

11.1 Category 5 Compensation payments made under legal obligation:

- These are identified as those where a clear liability exists as a result of a court order or a legally binding arbitration award. Payments into court and out of court settlements are not payments made under legal obligation*.

- Claims must be submitted to the Director of Finance, Procurement and Value for a decision. The advice of the Chief Executive will be sought as appropriate.

- No acceptance of liability must be given when a claim is received, only an acknowledgement that the claim is receiving attention.

* Legal obligation include employment tribunal rulings. Any settlement on legal advice outside of the tribunal must be treated as ex-gratia payments within the relevant delegated limit.

11.2 Category 6 - Extra contractual payments to contractors.

These are payments which, although not due legally under an original contract, appear to be obligations which a court might uphold. Any such payment must be justified on value for money grounds.

11.3 Category 7 Ex Gratia Payments

Ex Gratia payments are payments, which the ABUHB is not obliged to make or for which there is no statutory cover, or legal liability. There are five separate types of Ex Gratia payment:

i. Maladministration,
ii. Loss of personal effects,
iii. Clinical negligence and personal injury,
iv. Settlements on termination of employment,
v. Other cases.

Appendix 6 details the policy and procedure for all cases of claims for Ex Gratia Payments.

In all of the above cases an "ex gratia" form, attached in Appendix 7, must be completed by the manager of the department that incurred the loss. The form must then be submitted to the relevant department for processing as identified on the bottom of the form. Where the likely loss is in excess of £50K the form in Appendix 8 must be completed and submitted to the relevant department to be submitted to Welsh Government for further approval to write off the loss within the Health Board.

11.4 Category 8 - Extra statutory payments.

These are payments which the Secretary of State is not empowered by statute to make. Any proposal to make such a payment must be agreed jointly by the Director of Finance, Procurement and Value and WG.

12. Accounting for Losses and Special Payments

The accounting of losses and special payments is set out in the WG IFRS NHS Wales Manual for Accounts. The Director of Finance, Procurement and Value is responsible for ensuring details of losses and special payments are entered into the Losses and Special Payments Register (LaSPaR). Day to Day responsibility for accounting for losses and special payments is delegated to the Assistant Director of Finance - Financial Systems and Services.

13 Reporting of Losses & Special Payments in The Organisation

All losses are reported to the Audit, Risk and Assurance Committee in accordance with the Annual, Risk & Assurance work plan and terms of reference by the Assistant Director of Finance – Financial Systems and Services. The report will include a section setting out the recorded "loss" for the year to date alongside where the category of expense is considered and scrutinised within the Health Board. The purpose of the report to the Audit, Risk and Assurance Committee is to provide details of the financial impact of losses and also to provide the Committee with assurance that processes are in place to review and learn from all incidents.

14 Further Information

Enquiries regarding this procedure should be directed to either the Director of Finance, Procurement and Value or the Assistant Director of Finance - Financial Systems and Services

15 Audit

The procedure will be subject to internal audit review on an ad hoc basis.

16 Review

This procedure will be reviewed every three years unless a requirement arises earlier.

APPENDIX 1

Delegated Limits for "Write Off"

It is the responsibility of the Director of Finance to seek Welsh Government approval for claims that exceed the thresholds identified below with the exception of all clinical negligence and personal injury claims where the responsibility lies with the Medical Director

CATEGORY OF LOSS/SPECIAL PAYMENT		DELEGATED LIMITS £
A Losses (except in respect of primary care provider services)		
1.	Loss of cash due to:	
a.	theft, fraud, etc.	50,000
b.	overpayment of salaries, wages, fees and allowances	50,000
c.	other causes, including un-vouched or incompletely vouched payments, overpayments other than those included under 1(b); physical losses of cash and cash equivalents e.g., stamps due to fire (other than arson), accident and similar causes	50,000
2.	Fruitless payments (including abandoned capital schemes)	250,000
3.	Bad debts and claims abandoned:	
a.	private patients (Sections 65 and 66 NHS Act 1977)	50,000
b.	overseas visitors (Section 121 NHS Act 1977)	50,000
c.	cases other than a-b	50,000
4.	Damage to buildings, their fittings, furniture and equipment and loss of equipment and property in stores and in use due to:	
a.	culpable causes eg. theft, fraud, arson or sabotage whether proved or suspected, neglect of duty or gross carelessness	50,000
b.	other causes	50,000

DELEGATED LIMITS

			£
B Special payments (except in respect of primary care provider services)			
5.	Compensation payments made under legal obligation		FULL *
6.	Extra contractual payments to contractors		50,000
7.	Ex-gratia payments		
	a.	to patients and staff for loss of personal effects	50,000
	b.	for clinical negligence (negotiated settlements following legal advice) where the guidance relating to such payments has been applied	1,000,000 including Claimant's costs *
	c.	for personal injury claims involving negligence where legal advice obtained and relevant guidance has been applied	1,000,000 including Claimant's costs *
	d.	other clinical negligence cases and personal injury claims	50,000 *
	e.	other, except cases for maladministration where there was no financial loss by claimant	50,000
	f.	maladministration where there was no financial loss by claimant	NIL
	g.	patient referrals outside the UK and EEA guidelines	NIL

*** For all clinical negligence and personal injury cases (including court cases) the use of periodical payments should be considered for any settlement (exclusive of legal costs) involving costs to the NHS of £250,000 or more, or for lower awards when this represents good value for money. Proposed out of Court periodical payment awards require approval from the WG H&SSG FD.**

8.	Extra statutory and extra regulatory payments	NIL

C Losses and special payments in respect of provision of primary care provider services

Losses			Limit
			£
9.	a.	Losses due to overpayments to practitioners of fees, allowances or salary	
		i. involving fraud	1,000
		ii. other	1,000
	b.	Un-vouched or incompletely vouched payments	1,000
10.	Claims abandoned		1,000

D Special Payments

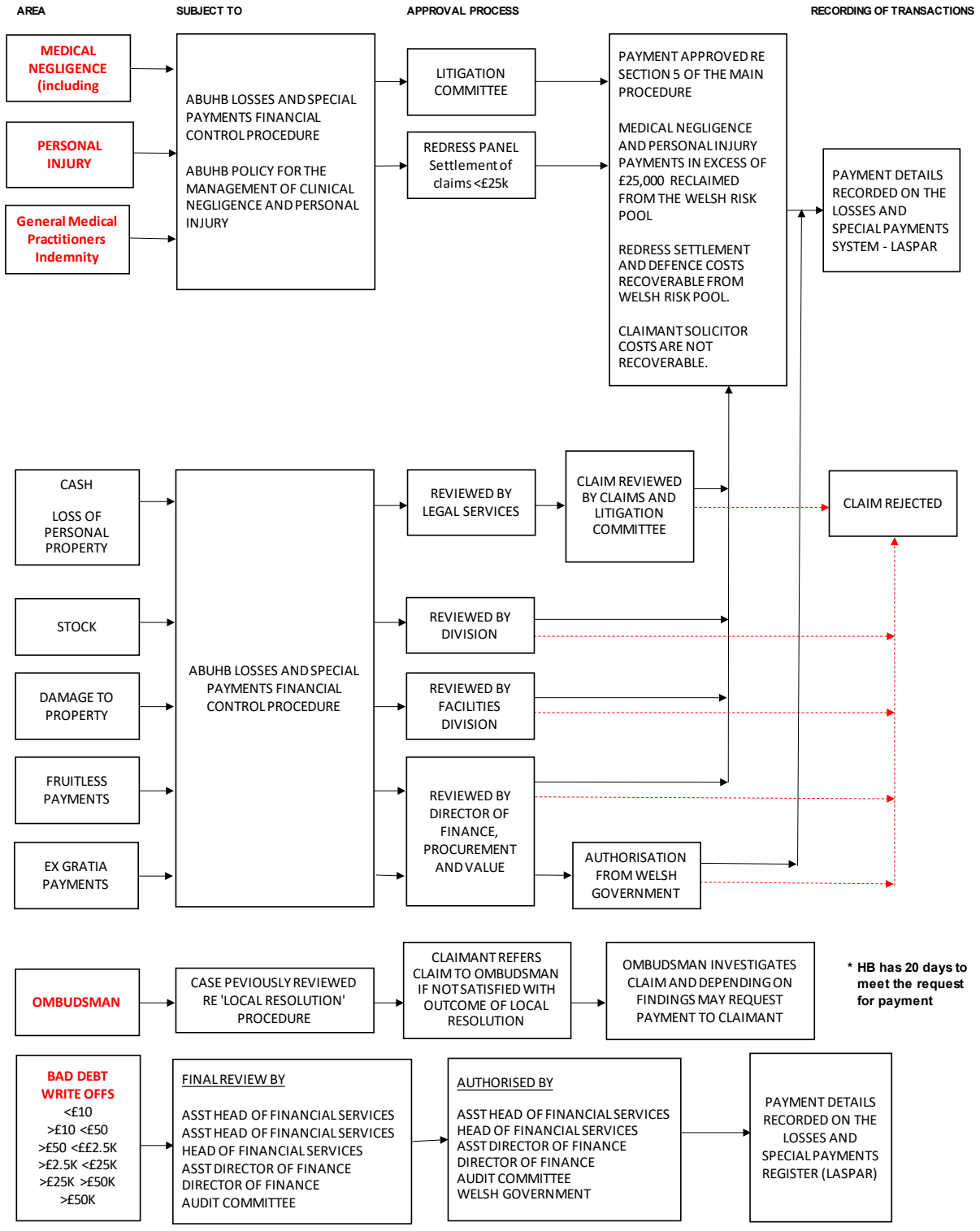
11.	Ex gratia payments		1,000
12.	Extra statutory and extra regulatory payments		
	a.	to pharmacist contractors for drugs supplied in good faith in respect of forged, etc., prescriptions forms	1,000
	b.	excusal of statutory charges for replacement dentures in certain circumstances	up to appropriate maximum statutory charge
	c.	other	NIL

E Losses: Fraud cases under investigation

13.	a.	Losses in cases investigated by the health body in respect of prescription fraud.	1,000
	b.	Losses in cases investigated by the health body in respect of dental fraud.	1,000
	c.	Losses in cases investigated by the health body in respect of ophthalmic fraud.	1,000

All ombudsman and bad debt write off payments are charged to the budget of the department where the incident arose.

Appendix 2



For all Medical Negligence & Personal Injury claims please also refer to the IFRS NHS Wales Manual for Accounts – Chapter 6 Losses & Special Payments
For all Redress claims please also refer to the WG 'Putting Things Right' Framework.

APPENDIX 3

LOSS REPORT – CATEGORY 1 LOSSES OF CASH

Name	
Title of Reporting officer	
Department	
Date	
Type of Case	
Reference	

Checklist/report

Detail the amount involved and the reasons why the loss arose	
If applicable, provide detailed breakdown of salary or other errors. What were the errors made?	
Can the loss be recovered? Provide details of the attempts that have been made to recover the loss (including legal action) or explain why no action has been taken.	
In fraud cases, obtain and complete a fraud report from the ABUHB Local Counter Fraud Specialist. Enter dates of completion of fraud.	
Consider whether the police should be informed of other category 1 losses. If no police involvement is necessary please give reasons. If appropriate please forward the police report (if available) to the WAG HFM Division	
Identify any failings in the actions of employees, including supervisors. Having considered this, is there a need for disciplinary action? Record what action has been taken or is proposed, or, if no action	

is to be taken, explain why. Include dates, names of individuals and positions.	

Was there any apparent breakdown of procedures? Detail weakness or fault in system of control or supervision.	
What proposed improvements have been put forward to correct defects in the existing systems or procedures? Include the timetable for implementation of the improvements.	
What monitoring measures have been introduced to ensure the improvements are working effectively?	
Having completed the above steps, detail the general lessons which can be drawn from this case.	

I have considered fully each point on this checklist and my findings are recorded in the attached case summary and/or in the spaces above. I confirm that the details recorded above and on the attached case summary are complete and accurate and that all aspects of the checklist have been properly considered and actioned.

Signed: ..... Printed: .....

Position: ..... Date: .....

Is it necessary to inform the Board/Chief Executive?

Yes ☐ No ☐

If no, please give reason:

Do the SFI's require a Board report for this case? If so enclose the report. If not consider whether in the light of this case your SFI's should be amended to require a Board report.	

I confirm that the above details are complete and accurate and all aspects of the checklist have been properly considered and actioned. I agree that the write off of this loss offers the best value for money in this case.

* *Delete as appropriate*

* This case is within the delegated authority of this Health body and is not novel, contentious or repercussive. I therefore agree to write off the loss.
* This case is above the delegated authority of this Health Body and is novel, contentious or repercussive and I therefore request formal approval from the WG Health Department

Signed: ..... Printed: .....

Position: ..... Date: .....

Countersigned by: ..... Printed: .....

Position: ..... Date: .....

This section must be completed by two senior officers in accordance with the delegated limits set by the Board.

Once completed this form should be returned to:-

Head of Legal Services
Headquarters
St Cadocs Hospital
Caerleon
NP18 3XQ

Appendix 4

LOSSES FORM

BANK CHARGES REIMBURSEMENT
(Due to late payment of salary)

Name of Employee ……

Payroll Number ……

Amount claimed £……

Evidence of charges incurred - 3 months bank statements □ (√ if received)
- copy of letter from bank □ (√ if received)

Period Covered ……...

Employee Error * Yes/No

Manager Error Yes/No

Payroll Error Yes/No

* If employee error no reimbursement to be made

Details of incident that led to charges being incurred

Prepared by: Approved by:

Name ……. Name ……

Title ……. Title ……

Signature ……. Signature …….

Financial Code to be charged 040-xxxx- 37300

APPENDIX 5

LOSS REPORT – CATEGORY 4 DAMAGE TO BUILDINGS, THEIR FITTINGS, FURNITURE AND EQUIPMENT AND LOSS OF EQUIPMENT AND PROPERTY IN STORES AND IN USE

Name	
Title of Reporting officer	
Hospital/Clinic	
Department/Ward	
Date/Time	

Checklist/report

Please provide details of the loss/theft/criminal damage/arson:	
Please detail the total value of items. Is the value of loss reduced by insurance? If so, please record the value of the gross loss and the value of the amount recovered by insurance	
Account Code	040-
Have the Police been informed?	Yes ☐ No ☐
If the Police have been informed, please provide details of the notification. ***Important Note:*** *Details of the outcome of police investigations must be notified to the Finance Director as soon as they become available*	
Please detail: • Any identified failings in the actions of employees, including supervisors and whether there is a need for disciplinary action	

• Any apparent breakdown of procedures	
Please state any future security measures or other corrective action which you feel should be implemented to help prevent a similar incident. If none, please state "None".	

I have considered fully each point on this checklist and my findings are recorded in the attached case summary and/or in the spaces above. I confirm that the details recorded above are complete and accurate and that all aspects of the checklist have been properly considered and actioned.

Signed: ..... Printed: .....

Position: ..... Date: .....

Once completed this form should be sent to:-

Assistant Director of Finance – Financial Systems and Services
Finance Department
Block C
Mamhilad House
Mamhilad
NP4 0YP

APPENDIX 6

POLICY & PROCEDURE FOR EX GRATIA PAYMENTS

1. INTRODUCTION

1.1 This appendix details the policy and procedure for ex gratia claims, in respect of cases not pursued as civil law negligence claims. It provides guidance to both managers and claimants to ensure swift and fair adjudication of claims.

2. INVESTIGATION

2.1 A standard form (appendix 7) must be used where a claim for compensation is being made for special payment (ex-gratia) to patients, visitors and staff for loss/damage.

2.2 The incident of loss or damage must be thoroughly investigated by someone of sufficient seniority to establish all of the relevant facts.

2.3 Any claimant who wishes to pursue legal damages should be referred to the Legal Services Department.

3. RESOLUTION BY GENERAL MANAGER OR EXECUTIVE DIRECTOR

3.1 The formal recommendation to agree or reject compensation will be made by the General Manager (i.e. ABUHB second-in-line managers) or Director and recorded on the claim form. A recommendation for compensation may not be delegated to another manager.

3.2 The General Manager or Director may recommend to reject a claim, or agree full or partial compensation. Compensation must be based upon the second hand value of the item. Full replacement value may be offered where it can be shown that the item was purchased relatively recently.

4. PAYMENT

4.1 Completed claim forms (approved and rejected) will be forwarded to Head of Legal Services at Headquarters, St Cadocs

4.2 The Head of Legal Services will then make a final decision as to whether to confirm the offer of compensation or rejection of the claim. This is formally recorded on the Claim form, signed and approved within authorisation limits If the offer is accepted, the claimant must complete and sign a Form of Discharge (Indemnity form) relating to the specific claim. Following receipt of this form signed by the claimant a cheque or BACS payment will be released from the finance department.

4.3 If the claimant wishes to appeal against the decision, appeals should be made to the. Head of Legal Services The matter will then be heard at the next Litigation Committee.

5. GUIDANCE ON COMPENSATION

5.1 General Loss and Damage

Compensation should be agreed where the investigation reveals on the balance of probability that there has been a failure of the ABUHB duty of care or of ABUHB procedures. Examples include patient property lost or damaged by staff; property lost or damaged after being handed in for safe keeping; and damage to staff property or clothing caused in the legitimate pursuit of their duties, providing that they were not themselves acting negligently e.g. not wearing protective clothing provided, or operating machinery or equipment against advice.

A judgement often has to be made about the state of capability or capacity of the patient. The ABUHB duty of care increases in respect of any patient, who is unconscious, has impaired mental capacity or is otherwise disabled in a way which compromises their ability to be responsible for their own affairs and security.

There may also be rare instances where, although the LHB cannot be described as negligent, justification may exist to support an ex-gratia payment to a claimant.

5.2 Lease Cars

A number of claims have been received in the past from lease car drivers seeking recompense for the excess insurance sum following an accident occurring during normal duties. To be consistent with the above general guidance, claims from any driver (lease car or owner driver) should be approved only where evidence exists that the damage relates to a failure on the part of the ABUHB or its staff. Accident claims against any third party for damage to a vehicle or contents should be pursued routinely via the driver's insurer, and will not therefore need to be considered by General Managers within the Losses procedure.

6. LITIGATION GROUP

The Litigation Group is chaired by the Chair of the Board and comprises of the Chief Executive, Medical Director, Two independent members with attendance by ~~.~~The Head of Legal Services

6.1 The role of the Litigation Group will be:

- To monitor consistency of claims decisions against Health Board Guidance.
- To review the case of any claimant wishing to appeal against a decision not to offer compensation or the amount offered. No further formal route of appeal will be available.
- To ensure that payments are made.
- To review and monitor the whole of the losses process and to provide advice to General Managers and Executive Directors

APPENDIX 7

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

Report No.
(for Office Use Only)

This form should be used to make a claim for compensation for:

- Financial loss resulting from an act or failure for Health Board or its staff which does not give rise to legal liability e.g. damage/loss to property belonging to a patient, staff member or visitor
- Hardship caused to persons by official failure or delay e.g. reimbursement of travel expenses following an appointment error

Sections A to J (excluding G) to be completed by staff member receiving the incident report

Section G to be completed, signed and date by Claimant (if present)

Section K to be completed by relevant Senior Manager

Section L to be completed by General Manager/Director

Section M to be completed by The Head of Legal services

Full name: :	Occupation & Band:	Division
Ward/Department	Contact No:	Date/Time reported:

Inpatient ☐ Outpatient ☐ Day patient ☐ Employee ☐ Visitor ☐ Contractor ☐

Full Name: .....

Male ☐ Female ☐ Age ☐ D.O.B. ☐

Address: .....

.....

Contact No. ..... Bleep/Pager No. .....

If Staff:

Occupation ..... Band: .....

Datix Incident Ref (if completed): .....

Date of incident ..... Time of incident: .....

Hospital or premises address where incident occurred: .....

Provide sketch if applicable

Location:

Normal activity carried out where incident occurred:

(Please attach copies of any supporting evidence):

E Details of Property Stolen, Lost or Damaged

(Please attach receipts and quotations if available at time of completion)

Description of items including serial numbers	State whether Organisational or private/personal property	Approximate age of items	Estimated value at time of loss £

F Has claimant expressed a specific wish to be reimbursed?

Yes ☐ No ☐ If yes, amount claimed .....

Are these items covered by personal insurance?

Yes ☐ No ☐

G Signature of Claimant *(if present)*

I can confirm that the facts on the previous pages are correct:

Signed: ..... Printed: .....

Date: .....

H Investigation and recovery action *(Cross through any question not applicable)*

Was property witnessed by a member of staff? Yes ☐ No ☐

Ownership verified by (full name): ..... Position/Band: .....

Search of ward/department carried out:

Date: ..... Name: ..... Position/Band: .....

Check of patients property book:

Date: ..... Name: ..... Position/Band: .....

Entry found in property book: Yes ☐ *If yes, attach copy* No ☐

Check of central Laundry:

Date: ..... Checked by: ..... Position/Band: .....

Police informed? Yes ☐ No ☐ **Crime No:** .....

Date: ..... Time: ..... Notified by: ..... Position/Band: .....

Date of Police Visit: ..... Name of Police Officer ..... Police Station: .....

I Other investigatory action by ward/department *(Please attach copies of any supporting evidence):*

J Person completing this report

I can confirm that the facts on the previous pages are correct:

Signed: ..... Printed: .....

Position: ..... Date: .....

NB: All structural damage must be reported to the Works & Estates Department. **Send this completed form immediately to the Directorate Manager responsible for the service/location.** Copies of this form can be located on the intranet.

NOTES:

(1) Special payments to staff for the loss of, damage to their personal items may only be made where:

(a) the incident occurs during the course of the employment.
(b) the articles lost or damaged are such as might reasonable be carried during the course of their employment
(c) the articles are sufficiently robust for the treatment they might reasonably be expected to bear.
(d) the loss or damage is not due to the staff member(s) own negligence.
(e) the loss or damage is not covered by insurance or by provision for free replacement

(2) Where the article can be repaired, the payment should cover the actual cost of repair, but where it is lost or damaged beyond repair, the value of the property immediately before the incident should be paid. This will be the cost of a replacement less the estimated amount by which the property has depreciated since purchase.

(3) The claim should be submitted as soon as possible after loss/damage has occurred. Any unreasonable delay could result in the claim being rejected.

K Senior Managers Report

(Please attach copies of any supporting evidence)

Provide detail of the lessons learnt and action taken:

Directorate Manager sign-off

Signature: ..... Printed: .....

Date: .....

L General Manager/Directors Approval

Yes ☐ No ☐ Cost Centre: 8560-37300

Please give your reasons:

I confirm that the details recorded are to the best of my knowledge accurate and that all aspects of this report have been properly considered and actioned.

General Manager/Director sign-off

Signature: ..... Printed: .....

Date: .....

M Approval by Chair of the Claims & Litigation Group

(a) ☐ The claim was considered and rejected

or

(b) ☐ The claim was considered and approved for £ .....

Signed: ..... Printed: .....

Date: .....

For office use only:

☐ Receipt/Quote

☐ Memo to Finance

☐ To CCL ☐ Approved ☐ Rejected

Completed forms should be forwarded to:
Head of Legal Services
Headquarters
St Cadoc's Hospital
Lodge Road
Caerleon
NP18 3XQ

If the estimated loss value is in excess of £50K – the Health Board will need to seek approval to write off the loss and as such appendix 8 will also need to be completed and submitted to Welsh Government for approval.

APPENDIX 8

FOR HEALTH BODY USE
Checklist to be used when compiling the summary of the case

Category – Type of case - Reference number - Health Body (name and code) -
1. Record the amount involved and the reasons why the loss arose.
2. Detail the background of case giving full reason why payment is necessary. Have other alternatives to the payment been investigated? If not, why not? If so, provide details.
3. **Was fraud involved?** If so complete a fraud report and ensure that the LCFS the relevant NHS CFS Wales team, Internal and External Auditors, and where relevant the police, are informed of the fraud in accordance with Welsh Government Directions to NHS Wales health bodies on Counter Fraud Measures and using the reporting system as specified by the NHS CFS Wales. Enter dates of completion of fraud report.
4. **Was theft or criminal damage involved?** If so have the police been informed? If not, give the reasons why not? All security related incidents must be reported to the Local Security Management Specialist once trained, accredited and in place in accordance with forthcoming guidance issued by NHS Security Management Service.

5. **For abandoned works**, were detailed specifications identified before the scheme went ahead? How did the projected work compare to these detailed specifications? At what level, by whom, and why was the scheme approved? Why was the scheme abandoned and by whom? Could the scheme have been aborted earlier? Was the scheme joint financed? If so, was any agreement signed? Was legal advice taken in the drawing up of an agreement? Is the other party prepared to pay half of the costs of the scheme?
6. **For Bad Debts and Claims Abandoned.** Were invoices raised on a regular basis? Was the debt monitored and chased regularly? Were services withdrawn upon continued non-payment? Enclose report showing when invoices were raised and where relevant paid. For cases involving businesses – has the business gone into liquidation/receivership? If so, are you listed as a creditor and do you have confirmation of this from the liquidator /receiver? If not, why not? Are any dividends being paid out? Was the financial integrity of the business looked into before goods or services were supplied? If not, why not and have procedures been revised to ensure this is carried out in the future?
7. **For rental cases only** - did the tenant enter into lease agreements prior to occupation? If not, why not? If the lease was faulty investigate whether action can be taken against legal advisors who drew up the agreement? Provide an analysis of rent and services charges.

8. **For private patients** cases was an undertaking to pay signed? If not, why not? Was a full estimate of potential costs given and full deposit taken to cover these costs? If not, why not?

   For overseas private patients cases – have the relevant embassies been contacted for payment (if applicable)? For overseas visitors, are robust procedures in place in the NHS Body to identify and charge liable overseas visitors. If not, why not? Was the overseas visitor informed that he/she would be liable to pay for the full cost of treatment? Was treatment, in a clinical opinion, immediately necessary or urgent? If treatment was not urgent why was it given before obtaining a sizeable deposit?

9. **Stores (only)** - Are any linen losses calculated at 50% of the replacement value? Is this in accordance with the guidance? Is the total loss more than 5% of the total stock value? Confirm that the loss has been valued at book value less net disposal proceeds.

10. **For extra contractual payments to contractors.** Have other alternatives to the payment been investigated? If not, why not? If so, provide details. Provide detailed calculations on which the payment is based.

11. **For ex gratia payments.** Have other options been considered? If not, why not? Explain why an ex-gratia payment offers the best value for money. Confirm that the proposed payment does not place the claimant in a better position than if the error had not occurred? If it does, why? In cases of hardship record what evidence exists on this. Provide detailed calculations to support the proposed payment and demonstrate why the proposed sum is in accordance with the relevant paragraphs of this guidance.

    For settlements on termination of employment, has relevant central guidance on such payments been followed in all respects? If not, why not?

    For clinical negligence and personal injury cases has the relevant central guidance for such cases been followed in all respects? If not, why not?

12. Is the value of the loss reduced by insurance? If so, record the value of the gross loss and the value of the amount recovered by insurance.

13. Have all reasonable steps been taken to recover the loss? Provide details of the attempts that have been made to recover the loss or explain why no action has been taken. Has appropriate legal advice been sought? If not, why not? If advice has been sought, what recommendations were made and have these been followed? If not, why not?

14. Identify any failings in the actions of employees, including supervisors. Having considered this, is there a need for disciplinary action? Record what action has been taken or is proposed, or if no action is to be taken, explain why. Include dates, names of individuals and positions.
15. Was there any apparent breakdown of procedures? Detail weakness or fault in system of control or supervision.
16. What proposed improvements have been put forward to correct defects in the existing systems or procedures? Include the timetable for implementation of the improvements. What monitoring measures have been introduced to ensure the improvements are working effectively?

17. Is it necessary to inform the board/chief executive? If not, why not?
18. Do your SFIs require a Board report for this case? If so, please enclose the report. If not, consider whether in the light of this case your SFIs should be amended to require a Board report in such cases.
19. Having completed the above steps, detail the general lessons that can be drawn from this case. If a system weakness has been identified which has possible implications across the NHS the LCFS or the NHS CFS Wales should report the problem to NHS Protect using either the intranet fraud prevention referral system for fraud or the Area Security Management Specialist for security matters so that measures can be taken nationally to amend policy or systems.

20. Please give details of name and position of person forwarding this case for Welsh Government approval (if applicable). Give the date when this case was first brought to the attention of the Welsh Government DH&SS FD (if applicable).

    Name -

    Position -

    Date Welsh Government DH&SS FD notified -

21. I have considered fully each point on this checklist and my findings are recorded in the attached case summary and/or in the spaces above. I confirm that the details recorded above and on the attached case summary are complete and accurate, and that all aspects of the checklist have been properly considered and actioned.

    Signed by -

22. I confirm that the above details are complete and accurate and all aspects of the checklist have been properly considered and actioned. I agree that write off of this loss offers the best value for money for this case.

    * Note: Delete as appropriate.

    * This case is not novel, contentious or repercussive. I therefore agree to write off of the loss.

    * This case is novel, contentious or repercussive and I therefore request formal approval from the Welsh Government DH&SS FD

    Signed by - Date -

    Countersigned by - Date -

    Please note this section must be signed by two senior officers in accordance with the delegated limits set by the board. Please print names and position held in the organisation.

    Name - Position held –

    Countersigned by - Position held -

Aneurin Bevan University Health Board

Financial Control Procedure

Stores and Stocks

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

Status: DRAFT
Approved by: Audit Committee
Owner: Director of Finance

Issue date:
Review by date:
Policy Number: ABHB/Finance/0249

Contents:

1. Introduction

The procedure has been written to specify the control procedures needed within ABUHB for all items put in to stores and those treated as stock.

The procedure does not cover the detailed requirements of other control systems such as Oracle. Reference should be made to local operational procedures and user manuals for guidance on these.

2. Policy Statement

This financial procedure will provide detailed guidance and direction for those employees with direct responsibility for the requisitioning and issuing of stores and stock items within ABUHB to mitigate the risk of loss or potential fraud within the Health Board.

3. Aims

The financial control procedure will ensure that

- Accurate records of the quantities of all items in stores and stocks are maintained.
- The values of stores items are properly evaluated and regularly validated.
- Reliable and accurate information about stores and stocks is generated to support the ABUHB accounts.
- Management information is made available to assist in the overall inventory control process.
- There is adequate security in place to prevent loss and assist with the detection of fraud.

4. Objectives

The procedure will clearly identify the requirements for recording and accounting for stores and stock items and will clarify the distinction between items classified as stores items and those classified as stock items.

5. Scope

The document should be read and applied by all ABUHB employees that are charged with the management of Stores and Stock items.

6. Roles and Responsibilities

All employees charged with the management of Stores and Stocks within the ABUHB must ensure that a proper standard of inventory control is applied, as identified within the aims section above.

7. Definitions

The procedure will address the treatment of those items classified as stores items and those items classified as stock items separately as the distinction between these two terms is an important part of the procedure and specified below.

Stores items are defined as those that are purchased/made where:

a) Not all the items are used immediately,
b) It is necessary to have a quantity on hand,
c) There is a need to "control" the items in a secure place and record their receipt and issue

Items to be controlled in this way will normally be higher value items, where the consequence of loss is greater, those which are susceptible to theft or damage, or those that have to be controlled from, a legal view point e.g. drugs.

Stock items are those items complying with both a) and b) above but not c).

They will typically be lower value items, or those requiring frequent issues e.g. ward held items, where controlling them as stores would be impractical and difficult to achieve.

8. Principles of Control

One of the main requirements in effecting control over stores and Stock is to identify the following:

a) Which items are to be regarded as stores/stocks
b) Where these items are located within the ABUHB
c) Who is responsible for stores/stock control
d) Which type of stocktaking system is to be used

Effectively, the only items treated as Stores are drugs held by Pharmacy, Omnicell used in Theatres and Works and Estate building items held in the estates store.
All other items such as those held at ward level are to be treated as Stock.

All items, whether treated as Stores or Stock, must be subjected to the principles covering the acquisition, receipt of goods, and their subsequent storage and issue.

Particular controls to be observed are as follows:

8.1 Receipt of goods

Irrespective of the source of external supply, items must be checked straight away upon receipt against the Supplier's documentation and the purchase order to ensure that the quantities are correct and that no items are damaged or missing.

This checking must be performed by someone other than the requisitioning officer to ensure that the principle of segregation of duties is maintained.

Where it is not practical to verify all items immediately on delivery, e.g. where a large number of items are delivered in boxes on pallets, the verification must be carried out within 48 hours of receipt and the supplier’s paperwork should be endorsed as not verified.

Care should be taken to ensure that quantities are properly checked before the items are accepted because errors are difficult to rectify at a later time.

Any discrepancies found must be recorded and notified as soon as possible to the Supplier.

Goods delivered must always be stored in a secure place, e.g. where deliveries are made to a central store they must not be left outside pending checking for quantities etc.

Where items are delivered within the ABUHB, e.g. drugs from the Pharmacy to the Wards, they must be signed for in the same way as if they were delivered from an outside supplier. All supplies of pharmaceutical stock items will be accompanied by a computer generated delivery note which must be signed by both the Pharmacy when the

supplies are sent out and the receiving activity e.g. a Ward when received. The Pharmacy delivery note must be retained on file by receiving department for two years to comply with legislation.

8.2 Storage of goods

The ABUHB will maintain a list of items it intends to treat as Stores.

Where stores are maintained within Pharmacy, Theatres and Works and Estates the following principles need to be adhered. In general items in stores must be capable of being reconciled according to the following formulae:

OPENING BALANCE OF ITEMS (quantities)	= **O**
Add receipts for a period	= R
Deduct issues made during the period	= (I)
Deduct any items scrapped or disposed of	= (S)
CLOSING BALANCE OF ITEMS	= **C**

Goods held in the Pharmacy, Theatres and Works and Estates Stores should be on shelving or pallets or within the Omnicell Cabinet in Theatres to avoid damage in the event of a flood. The seals on the goods should be examined to ensure that the contents have not been tampered with or removed.

8.3 Security

Items must be secured at all times e.g. kept under lock and key and access to the key must be properly controlled where there is any possibility of physical loss. This is to ensure that the items in stock can be identified as the responsibility of a named individual(s).

Security of stocks is particularly important for Pharmacy items that are subject to legal as well as financial constraints.

In view of the need to protect items against fire hazards, advice should be obtained from the local ABUHB Fire officer and that advice must be complied with.

8.4 Receipts and Issues

Receipts of items into the store, and issues from it, must be fully documented. A system must be maintained and each entry in it must be supported by Supplier's documentation (for receipts) or issues notes (for

issues). The signature of a designated officer is needed to support all receipts and issues.

The list of responsible officers is regularly reviewed and updated.

A periodic reconciliation is carried out between the values of receipts, issues and stocks held.

Similarly, any items that are to be scrapped or decommissioned e.g. due to obsolescence, or broken/damaged beyond repair, must be fully documented and authorised and recorded as part of the year end stock taking exercise.

8.5 Stocks and Stores Records

A record needs to be maintained of items kept in store showing the physical quantities on hand.

This is to ensure that maximum and minimum stock levels are adhered to and that any discrepancies are revealed at the earliest possible stage. A typical record will contain the data shown in appendix 2 below together with a description of the item and the dates of the transactions. It is also important to monitor any changes in use.

8.6 Reordering and maximum/minimum levels

Items kept in Pharmacy, Theatres and Works and Estates stores need to have maximum and minimum levels set so that the numbers on hand do not become excessive, or do not fall to such a low level that the ABUHB runs out of stock.

Maximum and minimum levels are established automatically by the system utilised by the service responsible for the stores and reviewed at an interval not exceeding 6 months. The maximum and minimum levels should be authorised by a responsible officer and should only be changed by the signed authority of that officer.

8.7 Stocktaking

A full stocktaking exercise must be carried out at least annually. To improve control of stock items it is necessary to carry out checks of the more important items held more frequently. This is to ensure that the stock values needed to support the ABUHB balance sheet can be calculated, and to ensure that any irregularities are found at the earliest

stage.

The Pharmacy and Works and Estates Stores merit a regular stock checking programme and consideration should be given to a perpetual inventory system such as Automated Data Capture (ADC) and Omnicell which are deployed across ABUHB sites. This system involves the following steps:

a) Identifying the stores items that need regular stock checks, because, for example, of their high ABUHB value or the possibility of loss.
b) A plan is produced to show which of these items are to be counted at regular intervals during the year.
c) Items are then counted according to this plan and the results compared with the stores records. Discrepancies need then to be investigated for write off as necessary.

Two of the major advantages of the perpetual system are that:

a) It ensures that irregularities are shown up earlier than with the annual stocktaking system,
b) If the processes are accurately carried out, the annual stock check can be made easier.

Where it is clear that items have been physically lost or otherwise need to be written out of the accounts, the Assistant Director of Finance Financial Systems and Services should be advised with full details in accordance with the Losses and Special Payments financial control procedure.

All documents e.g. requisitions and issue notes, must be properly "underscored" after completion to ensure fraudulent additions cannot be made.

All stores records shall be in such a form and shall comply with such a system of control as the Director of Finance, Procurement and Value may approve.

9. Accounting for Stores and Stocks

When stock and non-stock items are purchased, they are charged to the cost centre that requested /acquired them.

At each year end a full stock check must be undertaken of all items of

stores and stocks. This must list all items held in store and be priced according to the principles issued by the Finance department.

The date of the annual stock-take will be agreed between the Business Partner Accountant and the
Service Manager and then notified to the Central Management Accounting team.

To ensure that the stocktaking processes are properly complied with, the Finance Department issue detailed instructions to all concerned detailing procedures that have to be observed. Appendix 1 provides details of the procedures issues which in summary include:

a) The identification and treatment of obsolete stock,
b) The means to avoid counting stock twice,
c) The means to ensure that all stock is counted, including that in transit at the time of the stock-take,
d) The requirement for all stock to be counted by 2 employees
e) Proper preparation of the area containing the stock so that the stocktaking is made easier. This will include such activities as the grouping of like items together,
f) The date and times of the stock-take,
g) The basis of pricing of stock including the accounting for VAT.

The stock sheets must be kept for audit purposes.

At each year end the value of the stores and stocks must be compared with the previous year's value, and the increase or decrease accounted for in the ABUHB financial accounts.

10. Responsibilities

The Director of Finance, Procurement and Value is primarily responsible for the accounting for the stores and stocks and for the accurate statement of their value in the accounts.

The management in charge of the department that controls the stocks, e.g., Directorate Managers, Estates Department, and Ward Managers are responsible for the proper custody of items under their control, and for the accurate recording of receipts and issues and taking stock in line with guidelines.

11. Ward Stock Procedures

Maximum and minimum stock levels have been set for all wards. It is the responsibility of Divisional Managers to ensure Ward Managers are aware of their responsibilities in this area and they comply with the audit protocol on Appendix 2. A system of spot checks must be carried out and the checks should be evidenced in accordance with the protocol.

12. Obsolete Stock

During the stocktaking procedures items identified as being unused for a period greater than 12 months should be recognised and the responsible officer must determine where stock is slow moving or obsolete.

If items have not moved for a period greater than 24 months or have been identified as obsolete after 12 months, then they should be segregated from the remaining stock and stores and not included in the periodic stocktaking procedures.

The responsible officer must approve disposal of obsolete stock. The Procurement Manager must be informed prior to disposal in an effort to ensure that any disposal proceeds are maximised. Any obsolete/written off stock should be recorded along with the value on the year end stock taking sheets.

Checks should be carried out on a regular basis to ensure that there is no 'out of date' stock on the shelves.

Where stock has a shelf life the stock should be rotated when restocking.

13. Audit

Annual audits are carried out in relation to stores and stocks by the internal department with further review if required undertaken by Audit Wales as part of the annual accounts sign off.

14. Review

The review period for the procedure is 3 years.

15. Glossary

Perpetual Inventory System – a program that continuously estimates your inventory based on your electronic records, not a physical inventory.

Consignment Stock – stock owned by one party but held by another.

Appendix 1

Aneurin Bevan University Health Board
Controlled and Non-Controlled Stores Stock Takes

Example of email sent to managers

I am writing to request that you arrange for controlled, non-controlled and consignment stock takes to be undertaken in the areas within your delegated budget.

The stock takes should be undertaken in accordance with the attached guidance.

The results of the stock takes will be incorporated in the Health Boards Annual Accounts for the year ended 31 March 2022.

Please be reminded that stock takes should only include items currently in use. Obsolete stock should be identified separately and written off as part of the stocktaking process.

Key requirements that must be adhered to.

- The **stock take *must* be undertaken during the period 01st February to 28 February 2022**
- **You must provide us with planned dates of the stocktakes by 24th January 2022. Please send an E Mail confirming your stock take dates and contact details to ABB_CMATeam**
- ***Once stock take dates have been notified to finance these must be adhered to.***
  (Late changes to the dates of inventory counts should be avoided. If unavoidable the change of date should be notified to the Financial Services and Accounting Team using the email above immediately and must allow sufficient time for either Internal or External Audit to attend the revised stock taking date)
- **Where possible please can you request budget holders to start and complete stock takes during the same day to prevent anomalies in the stock takes arising as a result of stock being issued and deliveries received.**

Completed stock take sheets should be returned to ABB_ CMATeam by 28th February 2022. This is to ensure that the charge/credit to expenditure and posting the results of the stock take to Oracle is actioned in the General Ledger in Month 11 (Guidance on the stock taking process is attached)

Finally during week commencing 21st March 2022, you will be asked to provide **written confirmation that there have been no material differences in stock levels on non–controlled stores between the dates of the stock take and 21st March 2022. These should be received by the CMA Team no later than 5pm on 1st April 2022**

Please contact the Team Leader – Central Management Accounts if you have any queries

Team Leader – Central Management Accounts 12th January 2022

Guidance Stocktaking Process
Controlled and Non-Controlled Stores

1. Stocktaking Process

1.1 Items purchased for controlled stores are charged to the store when purchased. Goods are issued from controlled stores on production of a requisition, the goods are valued at average cost and Budget holders are charged with the cost of goods issued.

1.2 Items purchased for uncontrolled stores are charged to Budget holders when purchased.

1.3 The value of Stocks and Work-in-Progress has to be shown in the Annual Accounts. The Manual for Accounts states that stocks, of consumable stores, raw materials and manufactured items held at the year end, are to be valued at the lower of cost or net realisable value.

1.4 A stocktake of all stores must be undertaken at least once per annum to provide a valuation of stock and work-in-progress for the annual accounts.

1.5 Stores should be kept tidy at all times and items stored should be clearly labelled, stored in storage containers (e.g. bins, drawers, shelves etc.) to aid the stock taking process.

1.6 Internal and External Auditors may attend the actual stocktake to carry out sample checks.

2. Stocktaking Process

2.1 The Finance Director or Delegated Finance Officer shall notify Budget holders, in writing, when and how stocktakes are to be undertaken.

2.2 All stock held on both controlled and non-controlled stores must be counted. Consignment Stock must be counted separately from ABUHB Stock. **The count must be undertaken by two members of staff, one employed in the department and another member of staff (either within the department or external to the department) to verify the count.** The members of staff undertaking the stock take count must ensure the accuracy of the count.

2.3 **Consignment stock must be counted separately and should be clearly identifies so not to be mixed in with normal stock.** The count must be undertaken by two members of staff, one employed in the department and another member of staff (either within the department or external to the department) to verify the count. **The members of staff undertaking the stock take count must ensure the accuracy of the count.**

2.4 S**upervisors are required to undertake a sample check of the counted stock to ensure the accuracy.**

2.5 All items must be counted and verified by both members of staff. It is not acceptable for 1 member to count the stock and for the 2nd member of staff to undertake a sample check on a number of items counted.

2.6 The count is to be recorded on stock sheets of an approved and acceptable design, the attached

excel file includes a worksheet as a pro-forma. Budget holders who wish to use a different stock sheet should check with the CMA Team that the design of the stock take sheet they propose to use is acceptable.

2.7 **All items of stock should be populated on the stock take sheets prior to the stock take being undertaken to ensure that all items have been recorded and to prevent any unnecessary delays whilst undertaking the stock take. This will facilitate more accurate and time effective counting.**

2.8 Stock should be counted based on the issues made e.g. if a box of gloves is issued per box and priced per box then the box should be counted. In a situation where individual gloves have been issued staff should count full boxes and half full boxes only – not the individual gloves remaining in an open box.

2.9 All inventory must be counted regardless of the value

2.10 Staff are reminded to keep an organised storage area whereby items with similar packaging are not mixed together.

2.11 Any stock decanted from the main storage area must be included within the stock take count

2.12 The stock sheets are to be:-

- **Completed in ink** or typed or a computer print out
- Different types of stock should be clearly identified and listed on separate sheets
- The officer undertaking the stocktake must sign any alterations. The use of correction fluid is not permitted
- The unit of stock must be clearly stated
- **Unit cost must be shown against each item and whether the costs include VAT or exclude VAT**
- Sequentially numbered in the format **1 of 6, 2 of 6,** etc.,
- Dated and signed by the Officer taking stock and the Officer verifying the stocktake
- Dated and signed off by a Senior Manager or the Budget holders.

2.13 The consignment stock sheets are to be :-

- **Completed in ink** or typed or a computer print out
- Different types of stock should be clearly identified and listed on separate sheets
- The officer undertaking the stocktake must sign any alterations. The use of correction fluid is not permitted

- The unit of stock must be clearly stated
- **Unit cost must be shown against each item and whether the costs include VAT or exclude VAT**
- Sequentially numbered in the format **1 of 6, 2 of 6,** etc.,
- Dated and signed by the Officer taking stock and the Officer verifying the stocktake
- Dated and signed off by a Senior Manager or the Budget holders.

2.14 The original stocktaking sheets are to be forwarded to the CMA Team for valuation. Photocopies are unacceptable.

2.15 Stock sheets not completed in accordance with these instructions will be returned to Budget holders for correction.

2.16 The CMA Team will

- Ensure that stock sheets are completed in accordance with this procedure
- Calculate the value of the stock
- Calculate the amount to be charged to/credited to expenditure
- Post the change in stock value to the ledger
- Notify the Budget Holder of the effect of the stocktake
- Enter the results of the stocktake on the worksheet in the excel file
- Provide access to all details of controlled stock, non-controlled stock and Consignment stock to the Financial Accounts Team

STOCKTAKE	**Year ……**			
SITE_____			SHEET NO:_____OF____	
DEPARTMENT _____			DATE _____	
STORE TYPE _____				
			UNIT COST	VALUE
DESCRIPTION	UNIT OF ISSUE	QUANTITY IN UNITS	VAT £	VAT £
	TOTAL BROUGHT FORWARD			
	TOTAL CARRIED FORWARD			
STOCK TAKEN BY:	CERTIFIED BY:		SIGNED OFF BY:	
NAME (BLOCK LETTERS)	NAME (BLOCK LETTERS)		NAME (BLOCK LETTERS)	
SIGNATURE:	SIGNATURE:		SIGNATURE:	
DESIGNATION:	DESIGNATION:		DESIGNATION:	

Appendix 2

ANEURIN BEVAN UNIVERSITY HEALTH BOARD
AUDIT PROTOCOL FOR
MINIMUM AND MAXIMUM STOCK LEVELS

1) On receipt of stores/stock from the NWSSP Central Stores, it should be checked and stored away on the same day.
2) No stock should be stored at floor level without the support of a pallet unless stored in a racking system.
3) All bulk stock should be kept under lock and key.
4) No stock should be crammed into storage areas to prevent damage and risk implications.
5) Stock should be kept in one area only other than what may be in use at any one time.
6) There should not be any stock held over the Maximum agreed level.
7) Stock should be kept in original boxes etc., where possible, especially Syringes (Needles) to identify expiry dates and to identify stock levels (Blood Bottle).
8) Each Ward and Department should be able to give two names of nominated staff who control the ordering.
9) Any member of staff, if approached, should know the procedure on how to obtain a credit from Stores using the appropriate correspondence.
10) Staff should be aware of the procedure used for requisitioning and ordering via Oracle.
11) Staff should be aware of the Protocol should they have a complaint about any item of stock.
12) The storage areas should be in a clean and tidy environment.
13) Stock which is used the greatest should be stored the closest to the Store-Room entrance.
14) NO STOCK e.g. Universal Containers etc., should be stored in the sluice area.
15) Each Ward/Department Manager should encourage Junior Staff to keep the Store Room in a manageable condition. This will also allow them to have an understanding of stock and what it is used for.
16) There should not be more than one box/package of any one item opened.
17) Stock should be rotated. Last in at the back. (Possibly numbering or dating boxes etc.)
18) Where possible, blood bottles should be ordered x 5 packs. Each pack contains 20 blood bottles. 1 box contains 5 packs. All Blood bottles should be stored in the original boxes. This enables easier identification of expiry dates.

Summary Position on Financial Control Procedures

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

Audit, Risk & Assurance Committee

Losses and Special Payments Report

Executive Summary

- **Purpose**

  To provide the Audit, Risk and Assurance Committee with information in relation to financial losses and special payments made by the Health Board between 1st April 2022 and 31st July 2022.

- **Background and context**

  Losses and Special payments are reported in the financial position monthly and reported to the Audit, Risk and Assurance Committee in line with the Committee's terms of reference.

  The main content of the report is in the Losses and Special Payments table and sets out the recorded "loss" for the year to date alongside where this category of expense is considered and scrutinised within the Health Board.

  The report also provides details of the provision held by the Health Board in relation to all outstanding Medical Negligence, Personal injury and redress claims which are currently under review. This provision is, in effect, a view into the future potential cost to the NHS in Wales of current cases. The provision does not represent a loss to the health board but forms part of the overall position in the accounts reported under losses and special payments.

- **Key Issues**

  The losses and special payments recorded during the period 1st April 2022 to 31st July 2022 totalled £11.0m of which £9.7m is recoverable from the Welsh Risk Pool (WRP), this means the actual loss to the Health Board is £1.3m. This is reflected in the year to date and forecast outturn position for the Health Board.

  In addition to the cost recorded above, a provision for clinical negligence and personal injury cases is recorded on the balance sheet and is based on the estimated potential liability as advised by Welsh Health Legal Services of the maximum possible future cost for all known cases. It has decreased by £7.3m since 31st March 2022 to an overall provision of £180.5m of which it is expected that £174.7m is recoverable from WRP leaving a potential future loss to the Health Board of £5.8m.

The decrease relates to a reduction in provisions for 3 large cases partially offset by increases in provisions in other cases.

- **Recommendation**
  The Audit, Risk and Assurance Committee is asked to note the content of this report.

The Audit, Risk and Assurance Committee is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views			
Receive the Report for Assurance/Compliance	✓		
Note the Report for Information Only			
Executive Sponsor: Rob Holcombe - Interim Director of Finance, Procurement and Value Based Healthcare			
Report Author: Estelle Evans, Head of Financial Services and Accounting			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board**	**Audit, Risk & Assurance Committee**
Date of the Report: 20 September 2022			
Supplementary Papers Attached: None			

Purpose of the Report

To provide the Audit, Risk and Assurance Committee with information in relation to financial losses and special payments made by the Health Board between 1st April 2022 and 31st July 2022.

Background and Context

See Executive summary above.

Financial Implications

1 Financial Analysis of Losses

LOSSES AND SPECIAL PAYMENTS 1.4.22 - 31.7.22

	No. of Cases	Amount of Loss or Payment			Type of loss/payment	Where reported/reviewed	Notes
		ABUHB £'000	Welsh Risk Pool £'000	TOTAL £'000			
LOSSES:							
Bad Debts	0	0	0	0	Various	Authorised by Division and notified/approved by Audit Committee	
SPECIAL PAYMENTS:							
Loss of personal effects	13	10	0	10	Minor Losses	Losses form completed - Authorised by Division and Putting Things Right team	Lost dentures, glasses etc.
Clinical negligence with advice	128	451	9,563	10,014	Clinical Negligence	Clinical negligence and personal injury - payment verified and lessons learnt addressed by the litigation committee for claims over £25K. Feedback into the quality and patient safety committee re Lessons Learnt. Reimbursement of payment made not processed by WRP until satisfied that lessons learnt have been clearly documented and implemented. Annual Report to Quality & Patient Safety Committee by the Litigation Department. Includes case type, numbers, financial information and historic comparisons.	
Personal injury with advice (includes Permanent Injury Benefit)	54	191	93	284	Personal Injury	As above	
Other clinical negligence and personal injury	11	12	51	63	Clinical Negligence and Personal Injury - claims under £25K	Redress committee for payments under £25K. Lessons learnt fed back to division	
Other	11	613	0	613	Various	Ombudsman cases - confirmed by putting things right team, other losses reports completed as appropriate	
TOTAL LOSSES AND SPECIAL PAYMENTS	**217**	**1,277**	**9,707**	**10,984**			
Of which, cases of £250,000 or more: Clinical negligence with advice	4	0	8,133	8,133			

2 Clinical Negligence and Personal Injury Provisions

The table below shows the analysis of the estimated liability for losses as at 31st July 2022 compared to the position reported at 31st March 2022. It reflects the estimated liability in relation to cases advised by Welsh Health Legal Services for both clinical negligence, personal injury and redress with the provision updated to reflect new or changed cases.

After the expected recoveries from the Welsh Risk Pool are taken in to account the estimated liability to the Health Board at the end of July 2022 is £5.7m.

Losses & Special Payments Provisions	31-Mar-22		31-Jul-22	
	No. of Cases	£000	No. of Cases	£000
Clinical Negligence	239	183,597	252	175,808
Personal Injury	68	729	72	1,436
Permanent Injury Benefit	21	3,262	21	3,132
Redress	26	185	17	127
Sub Total	**354**	**187,773**	**362**	**180,503**
Less WRP Recoverable: Clinical Negligence	(126)	(181,442)	(138)	(173,513)
Less WRP Recoverable: Personal Injury	(6)	(472)	(6)	(1,110)
Less WRP Recoverable: Redress	(26)	(170)	(17)	(110)
Net Liability	**196**	**5,688**	**201**	**5,770**

Recommendation

The Audit, Risk and Assurance Committee is asked to note the contents of the report.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	*The monitoring and reporting of losses and special payments is part of the Health Board's governance framework.*
Financial Assessment	*The financial impact of losses and special payments detailed in this paper are included in the reported financial position of the Health Board.*
Quality, Safety and Patient Experience Assessment	*This report has no direct impact on Quality, Safety and Patient Experience Assessment.*
Equality and Diversity Impact Assessment	*Not relevant to this summary paper.*

(including child impact assessment)	
Health and Care Standards	*This paper provides governance and assurance to the committee.*
Link to Integrated Medium Term Plan/Corporate Objectives	*The financial impact of losses and special payments are included in the Health Board's reported financial position. This links into the underlying financial position that supports the Health Board's 3 year plan.*
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*Not relevant to this summary paper.*
Glossary of New Terms	*WRP – Welsh Risk Pool*
Public Interest	*Report to be published in the public domain.*

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Thursday, 6th October 2022 Agenda Item: 3.4

Audit, Risk & Assurance Committee

Financial Accountability Arrangements

Executive Summary

This briefing paper identifies the key governance documents, guidance and controls which are established to ensure financial expenditure is managed within available resources.

The documents are available on the ABUHB intranet and share point sites for all staff and are copied (via electronic links) into the budget delegation letters issued to budget holders.

Key documents include:

- Standing Orders
- Standing Financial Instructions
- Budgetary Control Financial Control Procedure
- Scheme of Delegation

A summary is provided below of the most relevant paragraphs for reference.

The Committee is requested to note the report.

The Board is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views			
Receive the Report for Assurance/Compliance			
Note the Report for Information Only	X		
Executive Sponsor: Rob Holcombe, Director of Finance, Procurement & Value			
Report Author: Heulwen Griffiths, Head of Business Systems and Governance			
Report Received consideration and supported by:			
Executive Team		**Committee of the Board:**	**Audit, Risk and Assurance**
Date of the Report: 23/9/22			
Supplementary Papers Attached: N/A			

Purpose of the Report

This briefing paper identifies the key governance documents, guidance and controls which are established to ensure financial expenditure is managed within available resources.

Background and Context

ABUHB is facing significant service and workforce pressures which are driving financial challenge and significant risk to delivering financial balance for 2022/23.

This paper describes the key financial controls and governance 'rules' and behaviours which the organisation has established to ensure expenditure is managed within available resources.

These key documents are aligned with Welsh government requirements and best practice financial control procedures.

Assessment and Conclusion

The following excerpts reflect the key sections identified in terms of financial control and operating within available resources. Electronic links to the full documents are included for reference and key points are highlighted.

Summary

1. Standing Orders
   - 1.1 Reservation and delegation of LHB Functions (Page 19 Section 2)
2. Standing Financial Instructions
   - 2.1 Financial provisions and obligations of LHBs (Page 8 Section 1.3)
   - 2.2 Financial Duties (Page 18 Section 4)
   - 2.3 Non Pay Expenditure – Duties of Budget Holders and Managers (Page 36 Section 10.3)
   - 2.4 Pay Expenditure – Staff Appointments (Page 60 Section 14.3)
3. Budgetary Control FCP
   - 3.1 Roles and Responsibilities (Page 4 Section 6)
   - 3.2 Delegation and Accountability (Page 9 Section 7.4)
4. Scheme of Delegation

Main Document

1. Standing Orders

1.1 **Reservation** and delegation of LHB Functions (Page 19 Section 2)

2.0.1 *Subject to any directions that may be given by the Welsh Ministers, the Board shall make arrangements for certain functions to be carried out on its behalf so that the day to day business of the LHB may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Board must set out clearly the terms and conditions upon which any delegation is being made.*

2.0.2 *The Board's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:*

i) *Schedule of matters reserved to the Board;*
ii) *Scheme of delegation to committees and others; and*
iii) *Scheme of delegation to officers.*

all of which must be formally adopted by the Board in full session and form part of these SOs.

2.0.3 *Subject to Standing Order 4, the LHB retains full responsibility for any functions delegated to others to carry out on its behalf.*

2. Standard Financial Instructions

2.1 Financial provisions and obligations of LHBs (Page 8 Section 1.3)

1.3.1.1 The financial provisions and obligations for LHBs are set out under Sections 174 to 177 of, and Schedule 8 to, the National Health Service (Wales) Act 2006 (c. 42). The Board as a whole and the Chief Executive in particular, in their role as the Accountable Officer for the organisation, must ensure the LHB meets its statutory obligation to perform its functions within the available financial resources.

2.2 Financial Duties (Page 18 Section 4)

4.1.1 The Health Board has two statutory financial duties, the basis for which is section 175 of the National Health Service (Wales) Act 2006, as amended by the National Health Service Finance (Wales) Act 2014. Those duties are then set out and retained in the Welsh Health Circular "WHC/2016/054 - Statutory Financial Duties of Local Health Boards and NHS Trusts." They are as follows:

- *First Duty - A duty to secure that its expenditure, which is attributable to the performance by it of its functions, does not exceed the aggregate of the funding allotted to it over a period of 3 financial years.*
- *Second Duty - A duty to prepare a plan to secure compliance with the first duty while improving the health of the people for whom it is responsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.*

2.3 Non Pay Expenditure – Duties of Budget Holders and Managers (Page 36 Section 10.3)

10.3.1 Budget holders and managers must ensure that they comply fully with the Scheme of Delegation, guidance and limits specified by the Chief Executive and Director of Finance, and that:

a) All contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of both any commitment being made and NWSSP Procurement Services being engaged;

b) Contracts above specified thresholds are advertised and awarded, through NWSSP Procurement Services, in accordance with EU and HM Treasury rules on public procurement;

c) Contracts above specified thresholds are approved by the Welsh Ministers prior to any commitment being made;

d) goods have been duly received, examined and are in accordance with specification and order,

e) work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used

are of the requisite standard and the charges are correct,

f) No requisition/order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Board members or LHB officers, other than:

(i) Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars,

(ii) Conventional hospitality, such as lunches in the course of working visits;

This provision needs to be read in conjunction with Standing Order 8.5, 8.6 and 8.7.

g) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

h) All goods, services, or works are ordered on official orders

i) Requisitions/orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

j) Goods are not taken on trial or loan in circumstances that could commit the LHB to a future uncompetitive purchase;

2.4 Pay Expenditure – Staff Appointments (Page 60 Section 14.3)

14.3.1 Staff must only be engaged by authorised managers, in accordance with the Board's Scheme of Delegation. The engagement must be within the approved budget and funded establishment.

14.3.2 No Board member or LHB official may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration outside the limit of their approved budget and funded establishment unless authorised to do so by the Chief Executive.

3. Budgetary Control FCP

3.1 Roles and Responsibilities (Page 4 Section 6)

6.6 Budget Holders

A budget holder is defined as a person to whom a budget is delegated. At the lowest level the budget holder is defined as the person responsible for managing resources at the lowest cost centre level and is able to approve expenditure goods and services and pay related costs against a cost centre budget within financial approval limits set by their line manager. The line manager is likely to be managing a number of budget areas delegated to others within their management area but is nevertheless also a budget holder with responsibility for a number of budgets delegated to others.

Accountability for budgetary control is exercised through line management relationships and this principle applies through all tiers of management where budgetary control is applicable.

Specific responsibilities of budget holders are:

- *Budget holders are responsible for providing services within their respective budget*

- *Budget holders are responsible for monitoring monthly budgets, actuals and variance utilising the Finance Business Intelligence Tool (FBI) and liaising with the Business Partner Finance Teams as necessary.*
- *Budget holders must not exceed the budgetary total or virement limits set by the Board*
- *Budgets must only be used for the purposes designated, and any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive*
- *Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance, Procurement and Value*
- *All budget holders must provide information as required by the Director of Finance, Procurement and Value to enable budgets to be compiled and managed appropriately.*
- *To not incur any overspend or reduction of income without the prior consent of the Chief Executive subject to the Board's scheme of delegation*
- *No permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and workforce establishment as approved by the Board*
- *Develop recovery plans to address adverse budget variances*
- *Budget holders should keep a record of any recovery plan meetings with line managers and/or Division as appropriate.*

3.2 Delegation and Accountability (Page 9 Section 7.4)

Managers must deliver a balanced budget within each and every financial year.
The key principle of delegation is that accountability for budgetary control is exercised through the line management hierarchy. Budgets are therefore formally delegated through the management hierarchy. Budget holders must not overspend against their budget. The requirement to deliver within the allocated budget must therefore form part of all budget holder's annual objectives and be reviewed as part of the annual review process.
The principles of delegation mean that accountability for budget management is to the line manager. Review of performance against budget should therefore take place as part of the line management PADR process in the context of the wider performance review of quality, safety and other targets.

3.3 Performance Management (page 12 section 7.8)
Aneurin Bevan Health Board has a statutory duty to deliver its services within its allocated budget. The Board via the Chief Executive and tiers of line management formally delegates this responsibility to individual budget holders across the organisation. Budget holders are held to account for budgetary performance through formal line management arrangements and are expected to manage within delegated resources on both a monthly and annual basis. This requirement links to the Health Board's statutory requirement to manage within its Revenue Resource Limit.
Where budget variances arise the following actions must be undertaken by the budget holder and line manager in a formal process of escalation:

- *If a budget is overspent in any one month the budget holder where practicable will recover the position by the next reported period.*
- *If a deficit will take longer than one month to correct and recover then the*

budget holder and line manager will:

Either

- *agree recovery actions over a defined period*

Or

- *agree virements from another area of budgetary responsibility*

A record of actions agreed must be made. A suggested format for recording actions is shown in Appendix 2.

- *If a deficit cannot be recovered within a period of 3 months, or virements agreed with the budget holder, the line manager will be required to agree remedial actions with the Divisional Director.*
- *If remedial actions to recover the deficit or agree virements still cannot be agreed with the Divisional Director, the line management team will agree remedial actions or virements with the responsible Executive Director.*
- *If remedial actions to recover the deficit, or agree virements, still cannot be agreed with the Executive Director, the Chief Executive will agree remedial actions or virements.*
- *If there is continued failure to agree a recovery plan or virements, the Executive Director and Chief Executive will agree remedial actions with the Audit Committee and Board.*
- *A record of the meeting to discuss and agree recovery actions must made. A suggested proforma is attached in Appendix 2 to record agreed actions.*

Budgetary control must form a key objective each year for all management staff with budget responsibilities.
Managers will be held to account for not meeting budgetary targets and subject to formal review as part of their wider performance management review with their line manager.

Recommendation
The committee is requested to note the content of the report for information and reference.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Risk of achieving the Health Board's statutory financial duties. Risks of non-compliance.
Financial Assessment, including Value for Money	Compliance with Governance and control procedures should improve financial control and value for money.
Quality, Safety and Patient Experience Assessment	This paper links to AQF target 9 – to operate within available resources and maintain financial balance.
Equality and Diversity Impact Assessment (including child impact assessment)	Applicable to all ABUHB activities.
Health and Care Standards	This paper links to Standard for Health services One – Governance and Assurance.

Link to Integrated Medium Term Plan/Corporate Objectives	Governance Controls should support delivery of all aspects of the IMTP and corporate objectives.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** **Integration** – **Involvement** – **Collaboration** – **Prevention –** Financial governance is a universal control to support the best use of public resources and decision making for public benefit.
Glossary of New Terms	n/a
Public Interest	Open, public documents

Internal Audit Progress Report

Audit, Risk and Assurance Committee

October 2022

Aneurin Bevan University Health Board

NWSSP Audit and Assurance Services

Contents

1. Introduction

The purpose of this report is to:

- highlight progress of the 2022/23 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board') to the October 2022 Audit, Risk and Assurance Committee;
- highlight the change of the Children's Community Nursing Service – Children and Young People Continuing Care from an advisory review to an assurance review;
- seek approval for the change from an assurance to an advisory review for the Decarbonisation audit; and
- provide an overview of other activity undertaken since the previous meeting.

2. Progress against the 2022/23 Internal Audit Plan

There are 29 individual reviews in the 2022/23 Internal Audit Plan plus two to be reported from 2021/22, and provision for follow-up work (including time available for Medical Devices and Equipment if required).

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

Number of audits in plan (including 2 from 2021/22):	31
Number of audits reported as final	5
Number of audits reported as draft	1
Number of audits work in progress	7
Number of audits at planning stage	9
Number of audits not started	9

The following report has been issued since the meeting of the Audit, Risk and Assurance Committee on 2 August 2022:

AUDIT ASSIGNMENT	**ASSURANCE RATING**
Agile Delivery	N/A - Advisory
Job Evaluation Process	Reasonable
Children and Young People's Continuing Care	Reasonable
Integrated Audit Plan - GUH	Substantial

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

Within Appendix A we have highlighted in red, three audits that were projected for delivery to the October Audit, Risk and Assurance Committee. However, due to delays at the planning stage we have revised the anticipated delivery date for these reviews to December.

3. Summary of Findings

Limited assurance reports are considered by the Audit, Risk and Assurance Committee in detail. The following summary provides the Committee with the main messages from the substantial, reasonable, and advisory reports issued since the last meeting on 2 August 2022.

Agile Delivery (advisory review)

We provided an overview and assessment of the progress within the Health Board of implementing agile working arrangements, including Welsh Government requirements.

Overall, we found good arrangements and progress underway. For example, we found that 30% of staff are working in an agile manner, and thus meeting the Welsh Government target. This is driven forward with the Agile Delivery Group, a supporting framework and the introduction of agile working spaces and support at sites across the region.

However, we recommended the monitoring of deliverables through an overarching agile working plan, with SMART goals and defining what success looks like. We suggested obtaining a wider variety of views from staff, to help with the understanding of requirements across the Health Board.

Job Evaluation Process (reasonable assurance)

We sought to provide assurance that the Job Evaluation process meets the requirements of the NHS Job Evaluation Handbook (the 'Handbook') and is being applied effectively by the Health Board. It also sought to provide assurance that all posts that are banded through the job evaluation process are done so in a fair and consistent manner to ensure there is equality for all members of staff.

Overall, we rated this area as a strong reasonable assurance, based on the sample tested. There is good knowledge of the Handbook's requirements within the team and processes in place to incorporate these. Whilst there were only five staff side representatives (at the time of the audit), we found training sessions underway to train up to 20 members of staff at a time. These have been operating since May 2022.

However, we raised recommendations to update the supporting policies and to strengthen compliance with the job evaluation process, where we found forms and entries onto the computer system absent – although these were a low level of exceptions.

Children and Young People's Continuing Care (reasonable assurance)

Whilst this audit originally commenced as an advisory review, we undertook a significant volume of testing and therefore, we were able to conclude the review as an assurance output.

This review was originally requested by the Health Board in response to a limited assurance report completed for Mental Health and LD CHC Arrangements.

Overall, we focused on the mechanisms for ensuring the quality and safety of the Children and Young People's Continuing Care. We found that the Children's Community Nursing Service (CCNS) is a well-managed service with robust governance, accountability, and risk management mechanisms in place.

However, we did find that significant challenges are being faced by the service, with national shortages of staff and a lack of clarity over guidance requirements. However, we also found that the team were actively engaging with the wider Health Board and Welsh Government to find a solution to overcome these challenges.

Whilst we raised a series of recommendations, each of these are interlinked to the key points highlighted above - namely resource, monitoring of risk, partnership working, resource challenges and partnership working.

Integrated Audit Plans - GUH (substantial assurance)

The overall objective of this audit was to determine the adequacy of information provided in support of the Stage 4 (construction) defined costs claimed by the Supply Chain Partner (through selective testing of the account).

The appropriate methodologies were confirmed as having been applied to determine the final sums due. Based on the sample selected, we are content that the cost adviser has obtained sufficient supporting evidence and provided challenge to support the current assessment of the final account sum.

However, we did raise a low priority recommendation over a small amount of costs incurred for items that have not been able to be utilised. We provided a recommendation over a course of action to remediate this.

4. Change of Planned Audit Reviews

We completed a review of Children's Community Nursing Service – Children and Young People Continuing Care at the request of the Health Board. Due to the nature of the review, we assessed and tested a high level of evidence. Whilst the report was scheduled to be based on an advisory review, the volume of work completed was sufficient to be able to provide an assurance rating and ultimately, exceeded the threshold for an advisory review.

Therefore, whilst we have included limitations to the scope of the review, we have provided reasonable assurance over the areas tested. We wish to bring this to the Committee's attention and to ask them to **note** the change to the report output.

For the Decarbonisation audit, this was planned to be undertaken simultaneously across most NHS Wales organisations to provide assurance on their arrangements to reduce carbon emissions and control climate change.

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

Accordingly, the decision was taken to pause the work at this stage and to produce an overview report of the position across NHS Wales, based on the work undertaken to date, to support all organisations as they continue to grapple with the significant challenges that decarbonisation brings. Therefore, the Health Board will now receive an advisory review rather than an assurance audit. We are seeking **approval** from the Audit, Risk and Assurance Committee to this change in approach.

5. Other Activity

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

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

6. Recommendation

The Audit, Risk and Assurance Committee is invited to note the above and approve the change for the Decarbonisation audit to an advisory review.

Appendix A: Progress against 2022/23 Internal Audit Plan

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

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

Appendix B: Audit Assurance Ratings

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

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

Grange University Hospital: Financial Assurance (Final Account)

Final Internal Audit Report

September 2022

Aneurin Bevan University Health Board

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

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

Contents

Review reference:	SSU_ABUHB_2223_05
Report status:	Final
Fieldwork commencement:	14 July 2022
Fieldwork completion:	7 September 2022
Draft report issued:	20 September 2022
Management response received:	27 September 2022
Final report issued:	28 September 2022
Auditors:	NWSSP Audit & Assurance: Specialist Services Unit
Executive sign-off:	Nicola Prygodzicz, Chief Executive
Distribution:	Robert Holcombe, Director of Finance, Procurement and Value Chris Dawson-Morris, Interim Director of Planning Kelly Jones, Head of Capital Finance Hannah Capel, Associate Director of Capital Projects
Committee:	Audit Committee

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

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

Executive Summary

Purpose

The overall objective of this audit was to determine the adequacy of information provided in support of the Stage 4 (construction) defined costs claimed by the Supply Chain Partner (through selective testing of the account).

Overview

The total final account sum certified by the Cost Adviser provided for audit was £233,568,631.86 (exc. V.A.T).

The appropriate methodologies were confirmed as having been applied to determine the final sums due. Based on the sample selected, we are content that the cost adviser has obtained sufficient supporting evidence and provided challenge to support the current assessment of the final account sum.

While some matters requiring management attention are included within the detail of the report, no errors in determination of the final account were identified; and accordingly substantial assurance has been determined in relation to its derivation and support.

Report Classification

Substantial

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

Low impact on residual risk exposure.

Assurance summary [1]

Assurance objectives		Assurance
1	SCP Fees	Substantial
2	Subcontractor costs	Substantial
3	Equipment and materials	Substantial
4	Inflation and VAT	Substantial
5	Gain Share	Substantial

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

1. Introduction

1.1 The Grange University Hospital (GUH) opened on 17th November 2020. Additional works were requested by the UHB post completion of the main scheme, including Doctor's rest facilities, external footpaths, additional car parking and, more latterly, a Same Day Emergency Care (SDEC) unit; together with improvement work to expand the Emergency Department and the Children's Emergency Assessment Unit.

1.2 The contract was let via the New Engineering Contract (NEC); Option C (Target Cost with pain / gain). This form of contract charges defined costs (i.e., actual costs incurred, as defined to be eligible under the contract), up to the agreed (Target) price, with a share of any savings in the event of under-spend. Any over-spend is borne by the contractor (denoted "pain"), being capped by the Target Price.

1.3 The contract for the construction (stages 4, 5 & 6) was signed on 1st November 2017 with a Target Cost of £206,457,498, plus inflation. This has been increased by agreed Compensation Events (contractual uplifts). The out-turn cost is set against this revised target for purposes of calculating "gain share", which is added to the out-turn cost to derive the sum due.

1.4 The sum due at the account presented for audit was £233,568,631.86, as follows:

	(£)	**(£)**	
Target Price - Stage 4		206,457,498.00	
Total Agreed Compensation Events		33,005,349.00	
Total of the Prices		**239,462,847.00**	(A)
SCP Allowed Defined Cost at Completion (including agreed compensation events)	216,739,883.80		
Plus Fee (5.4%)	11,703,953.73		
Price for Work Done to Date at Completion		**228,443,837.53**	
Estimated final Account	229,213,257.91		(B)
Estimated contractors Share payable = (A - B)* 50%		5,124,794.33	
Total Paid to the Contractor at Completion		**233,568,631.86**	

1.5 The audit was undertaken to determine the adequacy of the information provided in support the level of Stage 4 (construction) costs at the final account.

1.6 The risks considered within this audit included expenditure not being appropriately supported; the account being over-paid; and the account being disputed.

2. Detailed Audit Findings

Rates and fees: Assurance that the SCP rates/fees are in accordance with national framework provisions and the signed contract.

2.1 Fees applied by the Supply Chain Partner were found to be in accordance with the contract.

Sub-contractor costs: Assurance that sub-contractor costs are appropriately supported and agreed.

2.2 A sample of sub-contractor accounts were reviewed during the audit (£183,803,204: *97% of total sub-contractor costs*).

2.3 Sub-contractor claims can be subject to adjustment prior to final agreement. The audit therefore sought signed agreement from sub-contractors accepting the final sum. These were available for all accounts, excepting those involved in on-going works.

2.4 Review of the accounts noted a balance of £10k (less than 1% of the sub-contractor accounts sampled) in relation to fencing which remains un-used, in storage on site. Accordingly, there is a need for appropriate action to be taken in respect of this e.g., a buy-back negotiated; or use at another project (**MA 1**).

Rebates, contingencies and estimates: Assurance that any rebates, contingencies, provisional and estimated sums have been removed from the account.

2.5 No rebates or contingencies were found to have been included in the final account.

2.6 The final account as presented for audit included an estimated sum of £624k in respect of sub-contract works contracted, but yet to be charged. The UHB will need to satisfy themselves on the accuracy/content of the same. While the main build has been completed, at the time of the audit post completion works under the contract remained ongoing; anticipated completion by the end of September 2022 (excepting any further instructions).

2.7 These post completion works were being agreed by way of Compensation Events, uplifting the contract price. At the date of the audit, the Cost Adviser advised that only one Compensation Event remained to be added, which would not materially affect the account. The UHB will need to satisfy themselves on the accuracy/content of the changes.

Equipment, materials and other costs: Assurance that equipment, materials and other costs have been appropriately charged.

2.8 These costs were reviewed as follows:

Cost category	Value in the account	Sample size	Audit Conclusion
Wage and salary costs	£15,230,711	£15,642	*The sample was appropriately supported by timesheets and ledger records. Note: 10% of entries at Valuation 54 were tested.*
Materials	£2,318,668	£2,058,622	*Sample fully supported by invoices charges*
Equipment	£6,676,760	£4,434,948	*Sample fully supported by invoices charges*

VAT and inflation: Assurance that VAT and inflation have been appropriately applied.

2.9 The most recent VAT estimate, reported to Welsh Government (March 2022), was £48.31m.

2.10 The Cost Adviser confirmed that VAT discussions remain ongoing between the UHB's VAT advisers and HMRC. A final submission awaits confirmation of the final account, which is targeted for late October/early November 2022.

2.11 Inflation is also a significant sum in the account – reported to be estimated at £15.827m in the Project Cost Report (May 2022).

2.12 The Target Cost is uplifted by inflation to allow for increased costs across the course of the project. The methodology applied to calculate the sum was reviewed with no issues noted.

Gain Share: Assurance that the gain share calculation has been correctly assessed (with reference to authorised Compensation Events and taking account of any delay damages due).

2.13 Gain share was found to be appropriately calculated, and included, within the final account presented for audit.

2.14 The ongoing discussions with Welsh Government are acknowledged and it is recognised that the UHB will need to confirm the final forecast underspend (achieved upon agreement of the final account) and any associated sum for repayment to Welsh Government.

Matter Arising 1: Un-used fencing (Operation)			**Impact**
Charges should only include items fitted to the build. A Compensation Event (CE) was agreed for £10,815 in April 2022 in respect of fencing required for the extension to the car park. The expected approval process for the CE was applied and the fencing was delivered to site and invoiced at £10,190, as part of the Soft Landscaping work package. However, it was subsequently advised that planning permission for this extension was not provided. The fencing remains on site in storage; and the UHB should now consider the appropriate action to be taken for these goods e.g., future use at another project, negotiate a buy-back with the supplier			Potential risk that: • Money is not appropriately recovered.
Recommendations			**Priority**
1.1	Management should confirm appropriate action in respect of £10,190 of delivered fencing not utilised at the GUH project		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	Agreed.	November 2022	Programme Manager

Appendix A: 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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Children's Community Nursing Service – Children & Young People's Continuing Care

Final Internal Audit Report

September 2022

Aneurin Bevan University Health Board

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

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

Contents

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Executive sign-off:	Leanne Watkins, Director of Operations
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Committee:	Audit, Risk and Assurance Committee

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

Acknowledgement

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

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Executive Summary

Purpose

To consider the robustness of Children and Young People's Continuing Care (CYP CC) governance arrangements within the Aneurin Bevan University Health Board's (the Health Board) Children's Community Nursing Service (the CCNS, part of the Family & Therapies Division).

We focused on mechanisms for ensuring the quality and safety of the Children and Young People's Continuing Care delivered.

Overview

The review was requested by the Health Board in response to Operation Jasmine (Adult Complex Care) and parent/carer concerns raised at other Health Boards regarding CCNS-led CYP CC.

We found that the CCNS is a well-managed service with robust governance, accountability and risk management mechanisms in place.

The CCNS (and wider Division) faces some key challenges in the delivery of CYP CC which we wish to bring to the Audit Committee's attention:

- significant vacancies (national shortage); and
- challenges to working with LAs due to lack of clarity in national guidance.

These matters are being managed by the CCNS and Division and have been escalated within the Health Board and to Welsh Government. See paragraphs 2.13-2.17 / 2.29-2.33 and recommendation 3 in Appendix A.

Our full findings are set out in section 2. All recommendations and management actions are included in Appendix A. Appendix B sets out observations which management may wish to consider further.

Report Classification[1]

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Assurance objectives		Assurance
1	Governance and Management	Substantial
2	Risk Management	Substantial
3	Partnership Working	Reasonable
4	Concerns and Escalation	Substantial
5	Reporting and Scrutiny	Reasonable
6	Resource and Staff	Reasonable*
7	Training and Support	Substantial
8	Policy and Procedure	Substantial
9	Quality of Individual Patient Care	Reasonable

** Whilst we have provided reasonable assurance over this objective, the CCNS vacancies and national staffing shortages present a significant current challenge and longer-term risk to the sustainability of CCNS CYP CC.*

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
3	Managing resource and partnership working risks	6	Operation	High

[1] The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion. Report classification and recommendation priority rating definitions can be found here.

1. Introduction

1.1 Following the conclusion of the Gwent Coroners Inquests associated with Operation Jasmine, Aneurin Bevan University Health Board (the 'Health Board') undertook an internal reflection exercise – for assurance purposes – regarding its governance arrangements for Adults Continuing NHS Healthcare (CHC).

1.2 In 2021/22, we reviewed the arrangements for commissioning CHC and Section 117 care for adults with mental health (MH) or learning disability (LD) needs.

1.3 Due to Operation Jasmine and the outcome of a children's continuing care review at Cardiff and Vale University Health Board and Swansea Bay University Health Board, the Health Board requested that we review its quality governance arrangements for the provision of CYP CC through its CCNS.

1.4 The overarching objective of the review was to consider the robustness of CYP CC governance arrangements within the CCNS, focusing on mechanisms for ensuring the quality and safety of the CYP CC delivered.

1.5 An overview of the CCNS is set out on page 5.

Limitations of Scope

1.6 The review excluded:

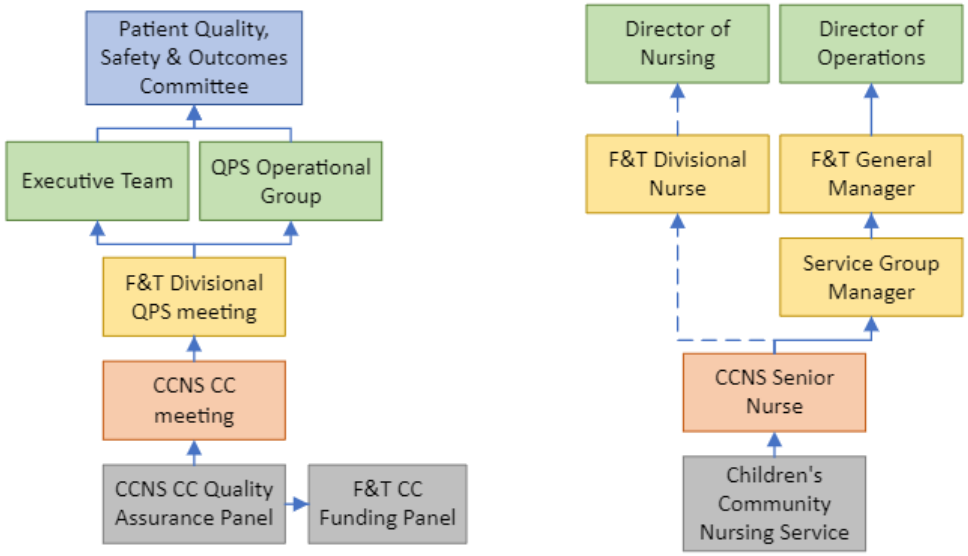
- CHC commissioning for adults and for individuals with MH/LD needs;
- transition of CYP CC patients to adult services; and
- CYP CC activities within Children & Adolescents Mental Health Service (CAMHS) and Children & Adolescents Learning Disabilities Service (CALDS).

Associated Risks

1.7 The key risk considered in this review was failure to identify and address inadequate care arrangements, potentially leading to poor patient / family experience or patient harm, failure to comply with relevant legislation or financial or reputational damage.

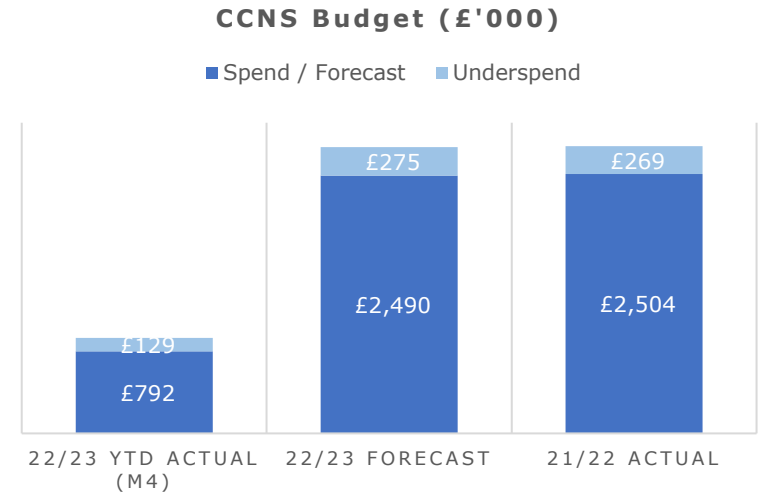
Children's Community Nursing Service at a Glance

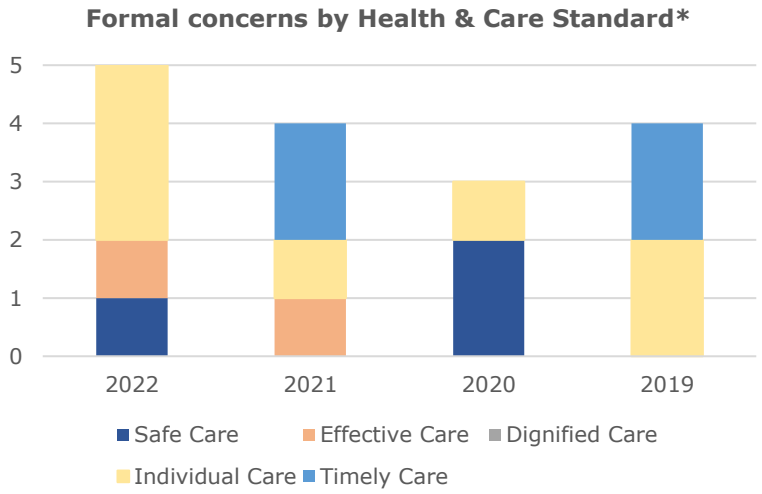
Governance, accountability and reporting structure:



Services provided by the CCNS:
- Children & Young People's Continuing Care (in scope)
- Specialist Schools (out of scope)
- Outpatient Clinics (out of scope)
- Care Closer to Home (out of scope)

CCNS staff	64 individuals
Compliance:	
- PADR	91.94%
- Statutory & Mandatory training	91.64%





* Formal concerns raised under the Putting Things Right or the Procedure for NHS staff to raise concerns processes. Also includes Children's Centres, which are not managed by the CCNS.

2. Detailed Audit Findings

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

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	2	3	5
Operating Effectiveness	1	-	1	2
Total	1	2	4	7

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

2.3 Our recommendations may also be relevant to CYP CC activities within CAMHS and CALDS. Therefore, the Division should consider the report in this light.

Audit Objective 1: CYP CC Governance and Management

2.4 CCNS priorities are identified within the Division's top priorities within the 2022/23 Integrated Medium Term Plan.

2.5 The CCNS has a clear line management, accountability and escalation structure.

2.6 There are identified forums for discussing CYP CC matters, with clear escalation routes to the Board.

Conclusion:

2.7 No matters were identified for reporting. Therefore, we have provided **substantial assurance** over this audit objective.

Audit Objective 2: CYP CC Risk Management

2.8 CYP CC risks within the CCNS are being managed and monitored by the Senior Nurse within Datix.

2.9 The CCNS team meeting provides a forum for discussion around risk.

2.10 Risks are escalated from the CCNS through the Divisional reporting structures. The most significant CCNS risk – vacancies and recruitment – has been escalated to the Executive Team.

2.11 The Senior Nurse has reviewed the target risk scores in line with what is achievable for the Service. However, they are not in line with the Health Board's risk appetite, and it is not clear if the Division or Health Board has reviewed and approved this. See recommendation 1 (low priority).

Conclusion:

2.12 Whilst a low priority recommendation has been raised concerning target risks scores, our work confirmed that CCNS risks (including CYP CC related ones) are well managed. Therefore, we have provided **substantial assurance** over this audit objective.

Audit Objective 3: CYP CC Partnership Working

2.13 There are several forums through which CYP CC partnership working between the CCNS, CAMHS, CALDS and LAs takes place.

2.14 The CCNS and wider Division is engaging with LAs to streamline CYP CC processes and ensure consistency in practice and decision-making.

2.15 Recent examples of working in partnership to improve processes include:

- recent decision to pilot a joint CYP CC assessment process; and
- development of joint CYP CC training.

2.16 Some partnership working mechanisms have only recently been implemented or are in pilot stage. See recommendation 2 (low priority).

2.17 The Division is aware that there remain key challenges to be worked through with the LAs, some of which depend on decisions being taken by Welsh Government (i.e., lack of clarity in guidance on what constitutes health care vs social care). The Division is taking action to address these challenges through the forums and mechanisms identified. See recommendation 3 (note: whilst this is a high priority recommendation, we consider it to have a medium priority impact on this audit objective).

Conclusion:

2.18 Whilst there remain key challenges to partnership working, the Division is proactive in engaging the LAs in CYP CC assessments and service improvement. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 4: CYP CC Concerns and Escalation

2.19 The CCNS follows the Health Board's concerns and escalation processes, including Putting Things Right, Safeguarding and procedures to raise concerns.

2.20 CCNS concerns and incidents are being managed and monitored by the Senior Nurse within Datix.

2.21 Significant concerns and incidents are escalated by the CCNS to the Divisional QPS meeting.

2.22 The Division also monitors concerns and incidents through its 'Closing the Loop' (CTL) report.

Conclusion:

2.23 No matters were identified for reporting. Therefore, we have provided **substantial assurance** over this audit objective.

Audit objective 5: CYP CC Reporting and Scrutiny

2.24 The CCNS team meets regularly to discuss key matters, including CYP CC.

2.25 The CCNS reports by exception to the Divisional QPS meeting via the Division's standard template.

2.26 The Division's CTL report covers QPS matters at a service level reported by Health & Care Standard.

2.27 Reporting is by exception only, there is no balanced performance report or supporting metrics. See recommendation 4 (medium priority).

Conclusion:

2.28 Noting the above, we have provided **reasonable assurance** over this audit objective.

Audit objective 6: CYP CC Resource and Staff

2.29 The CCNS Senior Nurse has undertaken demand and capacity analysis for the Service, including consideration of CYP CC.

2.30 The CCNS is facing significant challenges regarding staffing, vacancies and recruitment. The Service and wider Division are taking action to manage challenges to the extent possible, including:

- consideration of workforce restructuring for more effective use of the resource available;
- introducing a Band 4 Healthcare Support Worker role to attract and retain staff;
- as a last resort, commissioning CYP CC from Ty Hafan (although this presents other challenges – see section 2.2).

2.31 The staffing challenges are predominantly due to a national shortage of staff in this specialist area. This has been escalated to the Welsh Government.

2.32 This situation is exacerbated by the training requirements to deliver CYP CC packages – it can take up to 18 months to train healthcare support workers due to its complexity.

2.33 We were informed that some services provided by the CCNS are unfunded, which also impacts upon delivery of funded services, including CYP CC.

2.34 See recommendation 3 (high priority).

Conclusion:

2.35 The CCNS and wider Division are acting within their powers to manage the situation concerning CCNS vacancies and national staffing shortages. However, the current challenges remain significant and present a longer-term risk to the sustainability of CCNS CYP CC. Further Health Board support may be required in this area going forward. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 7: CYP CC Training and Support

2.36 The CCNS has a well-developed framework for ensuring staff are trained and regularly assessed.

2.37 The Service has a Practice Educator who oversees and delivers the training.

2.38 There is a mandatory CYP CC training module within ESR. Practical CYP CC training is currently delivered on an ad hoc basis.

2.39 Compliance with PADRs and Statutory & Mandatory training is monitored at a Divisional level.

2.40 The CCNS is currently heavily reliant upon agency staff to deliver CYP CC. It has implemented monthly monitoring to monitor the quality of care delivered by agency staff.

2.41 The CCNS does not currently have an overarching training and development strategy (we were informed the Practice Educator would like to develop one) or a programme of ongoing practical CYP CC training.

2.42 Staffing issues (noted in paragraphs 2.30-2.33) are impacting upon staff wellbeing and have created challenges in training delivery and attendance.

2.43 See recommendation 5 (low priority).

Conclusion:

2.44 The CCNS has good training and support mechanisms in place for CYP CC and our low priority recommendation relates to enhancing these mechanisms. Therefore, we have provided **substantial assurance** over this audit objective.

Audit objective 8: CYP CC Policy and Procedure

2.45 The Division has a CYP CC Policy (the Policy) with supporting procedures / templates covering CC activities across the CCNS, CAMHS and CALDS. This has been developed through the Division's Continuing Care Development Group, which includes representation from the LAs.

2.46 We identified areas where the Policy could be further strengthened. See recommendation 6 (low priority).

Conclusion:

2.47 Noting the above, we have provided **substantial assurance** over this audit objective.

Audit objective 9: CYP CC Quality of Individual Patient Care

2.48 The patient assessment and review processes are clearly set out in the CYP CC Policy and are in line with the national CYP CC guidance.

2.49 The LA and Education are engaged in the decision-making process

2.50 The CCNS Continuing Care (CC) Manager undertakes a compliance quality assurance (QA) review to ensure compliance with the Policy.

2.51 In our testing on five of the 16 CCNS CYP CC patients, we reviewed evidence that key aspects of the process had been complied with (see Appendix D for details of the testing undertaken). No exceptions were noted.

2.52 Patient / family / carer experience is covered in the monthly visits that CCNS Nurses make to each patient's home. The CCNS is also working with the Health Board's Value Based Healthcare team to develop patient experience metrics and mechanisms to effectively capture and monitor these.

2.53 There are no QA mechanisms over:

- CYP CC assessments / reviews;
- care delivered by the CCNS team; and
- care delivered by external providers (respite and commissioned CC, the latter being new to the CCNS).

2.54 There are some mitigating controls that reduce the related risk, including the agency package review process (paragraph 2.40), the monthly visits to each patient's home and the compliance QA process.

2.55 Additionally, the CCNS has 'proactive' quality controls in the level of training and support provided to its staff (paragraphs 2.36-2.39).

2.56 See recommendation 7 (medium priority).

Conclusion:

2.57 The CCNS needs to strengthen its approach to quality assuring there CYP CC delivered. Therefore, we have provided **reasonable assurance** over this audit objective.

3. Observations for Management Consideration

Staff Survey

3.1 We undertook a survey of CCNS staff involved in the management and delivery of CYP CC. 64 staff members were surveyed; 16 responses were received. The full results along with our analysis have been provided separately to Divisional and CCNS management.

3.2 The survey responses have been incorporated into the recommendations and observations for consideration in Appendices A and B, respectively.

3.3 Survey summary with RAG rated responses:

Question Area	RAG	Comments	Appendix ref
Respondents		Survey had a small number of respondents, only one of which was a HCSW.	B.2
Policy / procedure		No significant concerns identified, although staff need to be updated on the new CYP CC Policy and Procedures and reminded of their location.	A.6
Training / support		Responses highlighted the impact of resource issues on training delivery and attendance.	A.5
PADR / competencies		Concerns that respondents had not had their competencies recently assessed.	A.5
Concerns		Two respondents felt concerns may be heard but not acted upon.	B.2
Culture		No significant concerns identified, although a small number of respondents felt the CCNS is not valued by the wider Division.	B.2

Other observations

3.4 Throughout the course of our fieldwork, we also identified further observations for management consideration, including:

- an area where the Health Board could provide further support in response to the staffing challenges experienced by the CCNS – point 3 in Appendix B; and
- observations for strengthening efficiencies at the CCNS Quality Assurance and Divisional CYP CC Funding Panels – point 4.

3.5 All observations for management consideration are set out in Appendix B.

Appendix A: Recommendations and Management Actions

	Para.	Title (D/O[2])	Risk / Potential Impact	Recommendation	Priority[3]	Agreed Management Action
1	2.11	**Risk Target Scores (O)**	Non-compliance with Risk Management Framework.	Acceptance of target risk scores outside the tolerance levels should be made at an appropriate level and clearly documented in the risk register.	**Low**	1) Risk Register to be reviewed in light of service development and transformation opportunities. 2) Tolerance levels of risk for the service will be mitigated as far as possible within this workstream, clearly identified and understood with required transformation changes supported by both Division and Executive team. 3) Ongoing monitoring and scrutiny at Division/Executive on 2 monthly basis **Responsibility: Assistant Divisional Nurse / Division Lead QPS** **Target Date 30/09/22**
2	2.16	**Monitoring partnership working (D)**	Duplication of effort. Ineffective partnership working.	Implement robust communication mechanisms between the various partnership working forums (e.g., CC Development Group, Regional Integrated Complex Needs Panel, etc). Monitor the effectiveness of these forums and any new joint processes implemented.	**Low**	1) Strengthen partnership working with partners in addressing the reduction programme connected with the Welsh Government not for profit/eliminate agenda 2) Clarity of terms of reference for stages of Continuing Care Process to be agreed and communicated clearly with partners 3) Education strategy regarding Children's Continuing Care for multiagency teams to be finalised and implemented 4) Task and finish group to agree initial joint assessment process pre referral to Children's Continuing Care and inform eligibility checklist and determine what is an "unmet health need" 5) A monitoring and review process to be established to ensure ongoing effectiveness of forums. **Responsibility: Assistant Divisional Nurse/ Division Lead for QPS** **Target Date 30/11/22**

[2] C = Control Design: a gap in the design of the system or process giving rise to increased risk; O = Operating Effectiveness: non-compliance(s) with the laid down system / process giving rise to increased risk.
[3] Recommendation priority rating definitions can be found here.

	Para.	Title (D/O[2])	Risk / Potential Impact	Recommendation	Priority[3]	Agreed Management Action
3	2.17 2.30 - 2.34	**Managing resource and partnership working risks (O)**	Inability to manage significant risks. Potential risk to service sustainability.	Close Health Board monitoring of the key risks facing the CCNS to ensure: • appropriate action continues to be taken; and • support is provided to the CCNS as required – see point 3 in Appendix B.	**High**	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 mixed workforce resource required to deliver safe service across the various lines of commissioned service e.g. Continuing Care, Special Schools, Children's Out Patients, Clinical/Care closer to home 3) Business Case/Service Review to establish options of further efficiency and priority with the identification of discrete financial budget lines to meet assessed and agreed service priorities 4) Developing new roles/skill mix within the Children's Community Nursing Service to enhance service provision 5) Partnership Board/Welsh Government recommendation required to determine the prudent delivery of care described as ancillary and incidental care needs, and multi-agency responsibilities in its delivery. This will aid the alignment of Value-Based health care and Value-Based social care **Responsibility: General Manager / Executive Team** **Target Date 31/3/23**
4	2.27	**Performance report (D)**	Poor performance not promptly identified. Missed opportunities to share positive news.	Incorporate the use of the recently developed All Wales CCN Senior Nurse forum KPIs for CCNS within the performance monitoring process. Regular monitoring of the performance report within the CCNS with annual (minimum) reporting to the Division.	**Medium**	1) RL Datix to be utilised further to capture compliments as an initial step to provide more balance. 2) Key Performance Indicators for the Children's Community Nursing Service is being looked at within the All Wales Forum. Once finalised, these will be implemented locally and reported to Division two-monthly in line with QPS framework with appropriately agreed action plans supported 3) CIVICA has recently been commissioned by the UHB and will support the development of a dashboard to analyse service user feedback, key performance indicators and Quality outcome measures. **Responsibility: Assistant Service Manager** **Target Date 31/12/22**

	Para.	Title (D/O[2])	Risk / Potential Impact	Recommendation	Priority[3]	Agreed Management Action
5	2.41 – 2.43 3.3	**CCNS Training Strategy and training programme (D)**	Staff may not be adequately trained. Poor quality CYP CC.	Develop a CCNS Training Strategy to bring together and provide oversight for existing training activities. Implement a sustainable rolling programme of practical CYP CC training. Monitor the impact of the resource issues on training and competencies to ensure they are not adversely affected.	**Low**	1) Ongoing comprehensive training programme has re-commenced and is monitored for compliance. Compliance of training programme is currently affected by safe staffing needs – Division will continue to monitor expected improved compliance with mitigated workforce challenges 2) Compliance to be reviewed two monthly as per QPS framework and to allow for implementation of follow up actions. Reported to Divisional Management Team **Responsibility Senior Nurse & Practice Educator** **Target Date 30/11/22**
6	2.46 3.3	**CYP CC Policy and Procedure (D)**	Non-compliance with policy, procedure, laws or regulations.	Include links to the following within the CYP CC Policy to provide full clarity on requirements: • relevant laws and regulations; • relevant Health Board policies and procedures, e.g., those relating to escalation and concerns; and • relevant local processes not already reference, e.g., local procedures to support implementation of Health Board escalation and concerns. Include all roles and responsibilities and reporting lines for completeness, even though they follow the Divisional structure. Inform CCNS staff of recent updates to the CYP CC Policy and where the Policy is stored.	**Low**	1) Suite of policies and procedures have been undergoing review to ensure they are updated and make reference to concurrent local and UHB Policy as well as the wider National Policy and Legislation 2) Policies and procedures, guidelines, standards to be registered on the Intranet A-Z Policies and Procedures, and the Children's community nursing staff pages of Healthier Together Website for ease of access for the wider team 3) Terms of Reference updated and awaiting final Division approval/sign off. 4) Updated Continuing Care Policy **Responsibility: Division Director / Chair for CCC Panel** **Target Date 30/11/22**

7	2.53 – 2.56	**Quality assurance over CYP CC delivered (D)**	Non-compliance with policy, procedure, laws or regulations. Poor quality CYP CC which is not identified or addressed.	Develop quality assurance mechanisms to assess the quality of: • CYP CC assessments; • care delivered by the CCNS team; and • care delivered by external providers (respite and commissioned CYP CC). Incorporate the QA mechanisms into the CYP CC Policy.	**Medium**	1) Quality Assurance mechanisms have been under review and considered through the multiagency CC development group. This to be finalised and rolled out across services 2) CC policy will reflect clearly the mechanisms used for assurance **Responsibility Assistant Divisional Nurse / Division Lead for QPS** **Target Date: 30/11/22**

Appendix B: Observations for Management Consideration

	Para.	Matters for Consideration
1	3.4	The CCNS has recently begun discussing significant concerns at the CCNS Quality Assurance Panel as necessary. The CCNS may wish to update the Quality Assurance Panel terms of reference to reflect this.
2	3.3	The CCNS staff survey (summarised in section 3, full results provided to Divisional and CCNS management) highlighted some areas that management may wish to investigate further: • **Staff engagement:** The survey had a small number of respondents, only one of which was a HCSW. Do all team members feel engaged? Do they feel their voice would be heard? Are the current communication and engagement mechanisms effective? • **Vacancy issues impacting on staff wellbeing:** Discussions with CCNS staff and free text responses to the survey indicated the CCNS vacancy issues is having a knock-on impact on staff wellbeing, including: – uncertainty in working patterns due to frequent shift changes to cover illness and/or vacancies; – delivery and attendance of training is affected by the need to cover shifts (also addressed in recommendation 6); and – the feeling that there is little support when it is very busy. Are the current communication and engagement mechanisms effective in communicating the action being taken to manage this issue? Do staff feel they have a voice and that their concerns around wellbeing are being heard? Are they empowered to suggest or make changes which may improve their working environment or wellbeing at work? • **Concerns:** Based on our work, we saw concerns being acted upon and addressed. However, two respondents felt that concerns were heard but not acted upon. Is this isolated to these two staff members, or is it a wider feeling in the team who didn't respond? Is it because concerns haven't been acted upon, or is it that there is a lack of communication on action being taken? • **Culture:** Two respondents felt the CCNS is not valued by the wider Division. No explanations were provided. Is this isolated to these two staff members, or is it a wider feeling in the team who didn't respond? What is it that makes them feel this way and is there anything that needs to be addressed? This may be linked to the staff engagement point above. Some of these points may link back to the first point about staff engagement. The Division / CCNS may wish to use mechanisms such as focus groups, coffee mornings, staff feedback forms, etc to help support and improve staff engagement.

	Para.	Matters for Consideration
3	3.4	In response to the resourcing issue, the CCNS would like to trial delivery of CYP CC from a Health Board or similar property. We understand this approach to be less demanding on resource whilst providing respite away from the patients' homes We were informed this was trialled previously, with mixed success. Patients and families appeared to like this approach, but the location of the property used was not suitable for the service being delivered (the property was used due to it being vacant). Given the current resource challenges, the Health Board should consider if it is prudent to invest in such a trial in a more suitable location.
4	3.4	We attended the July 2022 CCNS Quality Assurance and Divisional CYP CC Funding Panels and identified the following points the CCNS may wish to consider: • both meetings overran – could the meetings be run more efficiently? Or should meeting invites be adjusted and flexed to allow for appropriate discussions and enable attendees to appropriately manage time? • information was missing for some patients, so decisions could not be made – is the compliance QA process identifying all that it should be? Is there a need for further education / guidance for referrers or process improvement to prevent this situation? • no representation from respite services (Ty Hafan) or Adult Complex Care (a child in transition to adult services was discussed) – would it be beneficial to have such representation at the meetings? • the Funding Panel agreed funding without considering the cost – whilst we appreciate eligibility is the driver as to whether the patient receives CYP CC, lack of awareness of the cost of packages may mean the decisions made by the Funding Panel do not represent value for money. The Division may wish to consider how it evidences consideration of value for money in funding decisions.

Appendix C: Terms of Reference

Scope	To consider the robustness of CYP CC governance arrangements within the Children's Community Nursing Service (part of the Family & Therapies Division), focusing on mechanisms for ensuring the quality and safety of the Continuing Care delivered. Areas of consideration: 1. CYP CC governance and management. 2. CYP CC risk management. 3. Partnership working with Local Authorities. 4. Triggers for service concerns and collating, analysing and reporting evidence, including escalation of concerns. 5. Reporting and scrutiny. 6. Resource and staff. 7. Training and support. 8. CYP CC policies and procedures, including mechanisms to ensure relevant legislation[4] is considered, addressed and complied with. 9. Regular assessment of CYP in receipt of Continuing Care, including: a. review of CC eligibility and Individual Care Plans in line with CYP CC guidance; b. demonstration of adherence to the principles of children's rights and wellbeing set out within The United Nations Convention on the Rights of the Child; and c. mechanisms for assessing the quality of individual patient care.
Associated risks	Failure to identify and address inadequate care arrangements, potentially leading to: • poor patient / family experience or patient harm; • failure to comply with relevant legislation; or • financial or reputational damage.
Limitations to scope	• CC commissioning for: – adults; and – individuals with learning disabilities or mental health needs. • Transition of CYP CC patients to adult services. • CYP CC activities within the Children & Adolescents Mental Health Service and the Children & Adolescents Learning Disabilities Service.

[4] For example, the Welsh Government's Children and Young People's Continuing Care Guidance, The United Nations Convention on the Rights of the Child, Mental Health Act 1983 After-care Section 117, Social Services and Well-being (Wales) Act 2014 and Additional Learning Needs and Educational Tribunal (Wales) Act 2018.

Appendix D: What We Did

Our approach was to:

a. undertake a review of key documents;

b. perform testing on a sample of the Division's CYP CC patients across the areas of consideration identified in the brief (Appendix One); and

c. interview key staff involved in the CCNS CYP CC process within the F&T Division.

To achieve this, we undertook the following review activity:

Interviews with key Health Board staff:

- Director of Nursing (at the time of the review);
- Divisional Nurse;
- Assistant Divisional Nurse;
- CCNS Senior Nurse;
- CCNS CC Manager; and
- CCNS Practice Educator.

Analysis of survey issued to all staff involved in CYP CC within the CCNS.

Review of supporting documentation to evidence compliance for the most recent CCNS CYP CC eligibility review for a sample of five patients:

- first assessment or annual review form for presentation to Panel;
- Decision Support Tool, including verifying patient / family / carer views had been documented;
- multidisciplinary team minutes, including verifying attendance of LA and Education representatives where appropriate;
- compliance QA form – to verify the compliance review by the CC Manager and to check the CCNS care plans had been updated within the previous twelve months; and
- Quality Assurance and Funding Panel minutes for one patient where the case was more complex.

High-level review of:

- National guidance – Welsh Government's The Children and Young People's Continuing Care Guidance January 2020;
- Health Board CYP CC Policy and supporting local procedures;
- local CCNS documentation supporting implementation of Health Board concerns and escalation processes;
- relevant reports and minutes for:
  - CCNS Quality Assurance Panel;
  - Divisional CYP CC Funding Panel;
  - CCNS team meetings;
  - Divisional CC Development Group minutes;
  - Divisional Quality & Patient Safety meetings;
  - Regional Integrated Complex Care Panel;
- CCNS training materials and competency database; and
- CCNS data from Datix for incidents and concerns.

Observation of the following meetings:

- July 2022 CCNS Quality Assurance Panel; and
- July 2022 Divisional CYP CC Funding Panel.

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Job Evaluation Process
Final Internal Audit Report

August 2022

Aneurin Bevan University Health Board

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

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

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Executive sign-off:	Sarah Simmonds, Director of Workforce and OD
Distribution:	Cathy Brookes, Head of Workforce Planning
Committee:	Audit, Risk and Assurance Committee

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

Acknowledgement

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

Executive Summary

Purpose

The review sought to provide assurance that the Job Evaluation process meets the requirements of the NHS Job Evaluation Handbook and is being applied effectively by the Health Board. It also sought to provide assurance that all posts that are banded through the job evaluation process are done so in a fair and consistent manner to ensure there is equality for all members of staff.

Overview

We have issued reasonable assurance for this area.

This audit focussed primarily on compliance with the Job Evaluation Process (the 'Process') between January 2020 to June 2022 and reviewed the different stages throughout. Whilst we did not identify any significant matters for reporting, we noted that:

- One of the key job evaluation policies has expired. Whilst amendments have been noted, the policy has not been ratified. The Health Board should ensure this is completed, so staff can access up-to-date information.
- On testing the different stages of the Process, we found instances where evidence was not available. The Job Evaluation Team needs to ensure that there is a complete audit trail in case of any future challenges.

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

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	N/A Not audited separately previously

Assurance summary[1]

Assurance objectives		Assurance
1	Policies and Procedures	Substantial
2	Compliance with the Process	Reasonable
3	Training and Support	Reasonable
4	Consistency Checking	Substantial

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Policies and Procedures	1	Design	Low
2	Compliance with the Job Evaluation Process	2	Operation	Medium

[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 the Job Evaluation Process (the 'Process') was completed in line with the 2022/23 Internal Audit Plan. The job evaluation process determines the value of a job in relation to other jobs within an organisation, to establish a rational pay structure. Job evaluation is a key part of the pay system that covers NHS staff with the 'NHS Terms and Conditions of Service Handbook' (Agenda for Change).

1.2 The introduction of the NHS Job Evaluation Scheme enables all posts to be banded through the job matching and evaluation process to ensure fairness, consistency, and equality for all members of staff. Aneurin Bevan University Health Board (the 'Health Board') is required to comply with the NHS Job Evaluation Handbook (the 'Handbook'). The Handbook covers areas such as mainstreaming (ensuring consistency) job evaluation, resolving blocked matching (comparisons to similar banded roles across NHS Wales), and the evaluation of jobs.

1.3 Alongside the Handbook there are procedures in place to help match and evaluate new posts and for those where there are significant changes that are likely to impact previous matched or evaluated job results. They should also be used where managers need to develop existing posts or enhance roles, for example, as a result of departmental restructuring. When replacing vacant posts, managers need to consider whether the same post is still appropriate or whether the role can be redesigned in line with service improvement and service needs.

1.4 The key risks considered in this review were:

- a lack of clarity regarding the Process, resulting in the poor co-ordination of service provision and incorrect outcome decisions;
- staff resources and skills are insufficient to operate the Process correctly; and
- the Process is not robust which undermines the integrity of the function leading to disputes and challenges over outcomes.

2. Detailed Audit Findings

Audit objective 1: The Health Board has appropriate policies and procedures in place which set out the job evaluation process and promote fairness, consistency and equality for all members of staff.

2.1 The NHS Wales Job Evaluation Handbook is the comprehensive guide for all NHS organisations on job evaluation. It is in its seventh edition and was last updated in September 2018.

2.2 The Handbook lays out 16 key factors for jobs and a set of proformas are in place to cover the key elements.

2.3 As part of the audit, we reviewed the Job Evaluation Page on ABUHB Pulse (ABUHB's staff intranet page) and can confirm the following policies and documentation were present:

- Banding of New Posts Policy;
- Re-evaluation of Existing Posts Policy; and
- Job description template / documentation

We confirmed that the above documentation underpins all the necessary requirements of the Handbook, working practices, and sets out the key roles and responsibilities whilst promoting fairness and consistency.

2.4 We confirmed the Banding of New Posts Policy has expired and was due for review in June 2019. From reviewing the document, we identified that amendments have been made and are marked in a red font. However, it is not clear whether the policy has been ratified by the relevant Policy group.

2.5 The policies and documentation on the Job Evaluation page on ABUHB Pulse are listed, but they are not hyperlinked for staff to access the necessary information quickly. The page is not user friendly and there appears to be a lack of communication and promotion of the Process.

This has been raised as **matter arising one.**

Conclusion:

2.6 The Health Board has policies, procedures and documentation in place which set out the Job Evaluation process and underpins the requirements of the Handbook and promotes fairness. However, the Banding of New Posts Policy is marked as expired. The policy has amendments included, but it has not been ratified. However, as the Health Board has access to the Handbook, as a key document, we have provided **substantial assurance** for this objective.

Audit objective 2: arrangements for managing the evaluation of new posts, re-evaluations of changed posts and outcome requests are robust and compliant with policy.

2.7 We confirmed that the Health Board meets the requirements for the matching and evaluation elements of the Process. We also tested the applicable information, to ensure a full audit trail is in place, including the job description, organisational chart, panel notes and R1 Form. Our sample testing identified that the information is recorded on an internal electronic file and, when required, on the national Computer Aided Evaluation system (CAJE).

2.8 Job matching is completed by partnership working between the Health Board's Job Evaluation Team and the line manager of the job that requires banding. Once the job description is completed it is then matched against a national profile and banded appropriately with the assistance of CAJE.

2.9 CAJE records panel members notes, of which there are usually two staff side representatives and two manager side representatives, and the points awarded

against each of the sixteen factors by using evidence linked to the job description. As part of our review, we tested a sample of twenty jobs, including higher and lower bands. We tested the different stages of the process to see if they were completed correctly. Overall, we found the process to be working well, apart from some minor instances where some information was not evidenced. This has been raised as **matter arising two**.

2.10 Job evaluation focuses on the completion of a Job Analysis Questionnaire (JAQ) and is completed when the job does not meet a national process. This process is completed when the post holder feels their duties and responsibilities are more than what is stipulated within their job description. A JAQ is completed and authorised by a line manager when the job does not meet a national NHS profile. We confirmed that job evaluations do not occur frequently, as the aim is for all NHS jobs to match to an appropriate national profile. During the timeframe reviewed (January 2020-June 2022), none have been completed within the Health Board.

2.11 Alongside job evaluation there is a job re-evaluation process. This occurs when the post holder believes they are working above their job description and are having to carry out additional duties and responsibilities. The post holder is required to complete a R1 Form and evidence the differences they feel they are working to. This requires a line manager and budget holder approval to progress.

2.12 Once the R1 form is completed, the changes stipulated on the form are reviewed by the Re-Evaluation Panel and discussion is based on whether the factors where the changes have been evidenced permit an increase in score or not. If there is an increase in scoring, then the band may increase, if a sufficient total is reached.

2.13 As part of the review, we tested ten jobs, a mixture from higher and lower bands, and tested the different stages of the process to see if they were completed correctly. We found instances where the process was not fully completed, this is discussed in Appendix A.

This has been raised as **matter arising two.**

Conclusion:

2.14 During the testing we were made aware that the Job Evaluation Lead for the Health Board was not available, so the process was being conducted by two other members of staff, who are both experienced in this process. There is a structured process in place for both elements of the Process (job matching and job re-evaluation). However, there are minor instances where there is a limited audit trail available. Therefore, we have provided **reasonable assurance** for this objective.

Audit objective 3: staff have received suitable training and support in relation to job matching, analysis and evaluation and outcome review requests.

2.15 The NHS Job Evaluation Handbook stipulates that all organisations need to ensure that staff are trained in matching, analysis, and evaluation elements of the NHS Job Evaluation Scheme for continuity. All training is nationally credited, job matching training is delivered over two days and evaluation and consistency training is one day each. If after the training the panel members feel under-confident, they can shadow an experienced panel before they formally participate.

2.16 We confirmed that there are five staff side and fourteen management side representatives in the Health Board. The number of panel members has decreased due to pandemic and work pressures. Work is currently being undertaken to increase the number of panel members, twelve took part in the training during May 2022 and there are 17 to be trained during September 2022. Only 20 members of staff can be trained as panel members within one session.

2.17 Between January 2020 and June 2022 there were 803 job matched posts and 53 re-evaluated posts within the Health Board. The Job Evaluation Team aim to hold a panel each month to meet demand. This also matches the commitment requirements for panel members too, that is one day a month. The Job Evaluation Team try to ensure there are different panel members sitting on job matching panels, however because of the low number of matchers there is an even lower number of evaluators and consistency checkers. This often means the same evaluators and consistency checkers are used on a regular basis. The Health Board has risk assessed this as a low risk compared to the high volume of jobs sitting waiting to go through the Process.

2.18 From the list of trained panel members, we held discussions with two staff side representatives and two managerial side representatives to obtain a summary of their experiences. All members confirmed they feel the process is robust and well managed and that they feel supported.

2.19 In terms of promotion, we confirmed that the ABUHB Pulse Job Evaluation Page for staff to access has limited information and promotion available. There is only a list of policies, one of which needs to be ratified, and guidance template documentation with no hyperlinks for easy access.

This is discussed in **matter arising one.**

Conclusion:

2.20 We confirmed there is adequate training and support for panel members, but that the promotional side requires updating. We found high staff numbers receiving training, which will continue to be important as the Health Board increases the overall number of panel members. Overall, we have provided **reasonable assurance** for this objective.

Audit objective 4: appropriate local consistency checking requirements are in place and meet the recommendations set out in the NHS Job Evaluation Handbook.

2.21 All job matching and job evaluation outcomes must go through a consistency check, which should be undertaken by experienced and trained job evaluation practitioners. The consistency element of the process must be completed with at least two panel members, with one being a staff side and the other a management side representative.

2.22 We can confirm there is a robust consistency checking process in place at the Health Board (as set out by the Handbook). As part of our detailed testing, we tested 15 consistency panels by completing a walkthrough of the process, reviewing any evidence on CAJE, testing the internal consistency form and reviewing email discussions electronically attached to the job. There were no issues raised as part of this testing.

2.23 Currently, the consistency panels are completed by a small pool of trained matchers, and this is because the Health Board has a limited number of panel members to call upon, as detailed in audit objective three. However, training is underway to increase the number of members. However, panel members who sit on the job matching panel cannot undertake consistency checks, to enable segregation of duties. As part of the testing, we did not identify panel members involved with both elements.

2.24 As mentioned previously, the Health Board utilises an internal consistency form, which is completed after every panel and then saved with the respective job. It is important to note this is not a requirement of the Handbook, but is an element of good practice, as it forms a stronger audit trail if any issues arise.

Conclusion:

2.25 We confirmed that the consistency process is completed as set out in the Handbook. The use of the internal consistency form is an element of good practice and acts as further evidence if any issues arise. Therefore, we have provided **substantial assurance** for this objective.

Appendix A: Management Action Plan

Matter arising 1: Policies and Procedures (Design)	Impact
The NHS Job Evaluation Handbook (the 'Handbook') is a national document which lays out the control environment for the job evaluation process (the 'Process') and has been adopted by all NHS Wales Organisations. The Handbook lays out 16 key factors for jobs and a set of proformas/templates to cover the key process operations. We tested the following policies, procedures, and supporting documentation: • Banding of New Posts Policy; • Re-evaluation of Existing Posts Policy; and • Job Description template / documentation. We confirmed that the Handbook requirements were incorporated into the policies / procedures. However, the Banding of New Posts Policy has expired and was due for review in June 2019. Subsequently, the policy has been updated, but has not been ratified by the relevant Policy Group. We tested the Health Board's staff Pulse intranet page and noted the key policies, procedures and documentation are listed there, but there are no hyperlinks for staff to quickly access the necessary information. The page is not user friendly and there is a lack of communication and promotion on job matching and job evaluation.	Potential risk of: • Health Board staff accessing out of date information. • Health Board staff not kept up to date with the relevant policies and documentation on the Health Board's staff Pulse intranet page.

Recommendations		Priority
1.1	The Health Board should review, update if applicable, and ratify the Banding of New Posts policy. Once this has been completed, the Health Board should ensure all related policies / procedures have been updated and linked correctly on the intranet page.	Low

Management response		Target Date	Responsible Officer
1.1	Recommendation accepted. Work has commenced to update the Banding of New Posts Policy in partnership with staff side lead, ensuring alignment with any recent JEG recommendations. First draft to be submitted to the Workforce & OD Policy Group in December 2022.	31st March 2023	Director of Workforce & OD

Matter arising 2: Compliance with the Job Evaluation Process (Operation)	Impact
All elements of the Job Evaluation Process (the 'Process') are completed with the help of the national aided Job Evaluation system (CAJE). Documentation relating to the process is saved as electronic files on CAJE. We were informed that 803 jobs were job matched between January 2020 - June 2022. We selected a sample of 20 job matched posts and tested the different stages of the Process to see if they were completed correctly. We found: • one job was not on the correct job description template and there was no organisational chart included (as required); and • five jobs did not have consistency forms completed, documenting the agreement of the Consistency Panel Members (this is a local Health Board process and not a requirement of the NHS Job Evaluation Handbook). Also, during the same time frame above we were notified that 53 jobs had been re-evaluated across the Health Board. A post holder completes a R1 Form that documents their duties that fall outside of their job description. This form must be signed off by the post holder, line manager and budget holder. During our review we tested a sample of 10 jobs that were re-evaluated and tested the different stages of the Process to see if they were completed correctly. We found: • one job was not on the CAJE system; • two jobs did not have internal consistency forms completed (whereas the others in the sample did as part of an audit trail) but dates of the panels were populated; and • two jobs did not have a date for a consistency panel populated and were not on the central database, so we are unclear if the panel took place. It is important to have a clear audit trail of evidence in case any challenges arise, and the decisions are questioned.	Potential risk of: • Job matching and Evaluation processes not being robust enough in keeping an audit trail, which undermines the integrity of the function leading to disputes and challenges over outcomes.

Recommendations		Priority
2.1	The Health Board should ensure that all necessary job evaluation documentation is completed correctly and centrally stored, to ensure that all posts have a comprehensive audit trail of how decisions are made.	Medium

Management response		Target Date	Responsible Officer
2.1	Recommendation accepted. The service will ensure the consistency process adhered to and administration processes are followed in line with agreed processes with all documentation filed in JE database/job library and using unique CAJE identifiers. Adherence to Job evaluation handbook guidance in terms of consistency checking and maintaining good job evaluation practices. To commence immediately. Development of Job evaluation intranet with all relevant document relating to job description to support good practice and links to existing policies with flow charts to support correct policy.	31st December 2022	Director of Workforce & 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.
 **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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Agile Delivery

Final Advisory Review Report

September 2022

Aneurin Bevan University Health Board

Contents

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Committee:	Audit, Risk and Assurance Committee

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Acknowledgement

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Disclaimer notice - please note

This advisory review report has been prepared for internal use only. Audit & 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.

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Executive Summary

Purpose of the Review

To assess the Health Board's progress in developing agile working practices and identification of good practice.

This is an advisory review and so, although management actions have been raised the review has not been given an assurance rating.

Summary of Health Board Position

	Area of consideration	Health Board position
1.	Agile delivery plan	
2.	Welsh Government guidance	
3.	SMART objectives	
4.	Health Board communication	

Key:

No concern	No risks or issues identified / recommendations identified for enhancing existing process
Strengthen	Management attention needed to address medium to low risk matters
Escalate	Urgent management attention needed to address matters of high risk with potential substantial impact

Overview of Findings

What's Working Well

- Staff have positive views on Agile Working and how the Health Board has supported Agile Working.
- 30% of staff are working in an agile way, meeting the Welsh Government target.
- There is an Agile Delivery Group which monitors the Health Board's progress on agile working. Senior Health Board staff attend this meeting from multiple directorates and as such, there should be sufficient engagement to ensure Agile Working is delivered successfully.
- The Health Board is trying to support agile working by opening up hot desking spaces at sites such as Caerleon House.
- There is a new agile working framework in place which details what the Health Board views as agile working and supports managers in how to best approach agile working within their teams.

Areas to Further Strengthen

- Welsh Government goals around agile working are being achieved. However, these goals do not form part of any agile working plan and therefore, may not be continuously monitored.
- Further engagement with staff to obtain their views on agile working would help ensure a diverse and up to date range of views are acquired.

Areas of Concern

- An overarching agile working plan does not exist.
- SMART goals on what success looks like from the Agile Delivery Programme does not exist.
- Overall, a more structure formalised approach to agile working would help to ensure the best efficiencies are achieved.

1. Introduction

1.1 The review of Agile Delivery was completed in line with Aneurin Bevan University Health Board's (the 'Health Board') 2022/23 Internal Audit Plan.

1.2 The concept of agile working gives employees the ability and the equipment to carry out their role securely, efficiently and successfully in different locations across the geographical area in which they work. Agile working is not just related to working from different locations or at different times. It is about gaining the benefit of utilising the available technology to change working practices, work differently, increase the effectiveness of the Health Board and change the culture to focus on outputs and outcomes.

1.3 Increasing levels of trust and autonomy to achieve improved productivity, efficiency and engagement, it is based on a concept of work being an activity rather than a place to go, with modern technology supporting new and different ways to meet service need, reduce costs, increase productivity and improve sustainability. Agile working can be undertaken in non-traditional environments through remote and virtual work, hot desking at alternate bases, sharing workspaces within the community, public sector, client sites or any other location.

Associated Risks

1.4 The key risks considered in this review are noted below:

- An agile delivery plan has not been developed in line with good practice guidance from the Welsh Government and does not treat staff in a fair and equitable manner.
- Planned changes are not adequately managed or controlled resulting in significant issues arising.
- The Plan is not delivered in a timely manner.
- Health Board staff are unaware of the proposed changes.

Advisory Review

1.5 Further details of the scope of the review and the work undertaken are included in Appendices One and Two.

1.6 This is an advisory review therefore we have **not provided an assurance rating**. We have identified learning and provided recommendations to strengthen and improve controls around agile delivery. Our recommendations are set out in Appendix Three.

2. Advisory Review Findings

There is an Agile Delivery Plan (the 'Plan') in place which has been appropriately approved

2.1 During the pandemic the Health Board worked towards becoming a more agile organisation, to assist the environment that it operated in.

2.2 However, the Health Board does not have a Plan in place for agile delivery. It does have a high-level vision noted within the newly developed agile / hybrid working Framework (the 'Framework'). Within the Framework there is a list of principles the Executive Team has agreed upon for the vision to be achieved.

2.3 The purpose of the Framework (released August 2022) is to draw together the essential elements of agile working and provide a guide which enables understanding of the principles and an ability to confidently implement agile working within each respective area of the organisation. The Framework does not detail how these principles will be followed, nor the goals or timeframes for each to be achieved. Given there has been significant change recently within the Executive Team it may be useful to re-evaluate these principles to ensure they are still relevant. This has been raised as **management action one.**

2.4 Within the Integrated Medium-Term Plan (IMTP), the Health Board notes that agile working will be considered alongside the Estates Strategy. Detailed in the Health Board Estates Strategy 2018 – 2028 (Strategic Objective 15), it says the Health Board would introduce a clear policy on the adoption of agile working principles as a means to assist in the reduction of the significant amount of office accommodation within the organisation.

2.5 The policy referenced has not yet been created. Without setting out a clear vision and goals to achieve the vision, it is difficult to see how the Health Board can complete a benefit analysis and accurately understand whether their implementation of agile working has been a success. The Health Board is aware of the need for the Framework, as this was noted within the July 2022 highlight report provided to the Agile Delivery Group.

2.6 Consequently, the Health Board should set out what it wishes to achieve with agile working, so that the organisation's efforts can be focused on the realisation of the benefits. This has been raised within **management action two.**

The Plan has been developed in line with Welsh Government Guidance

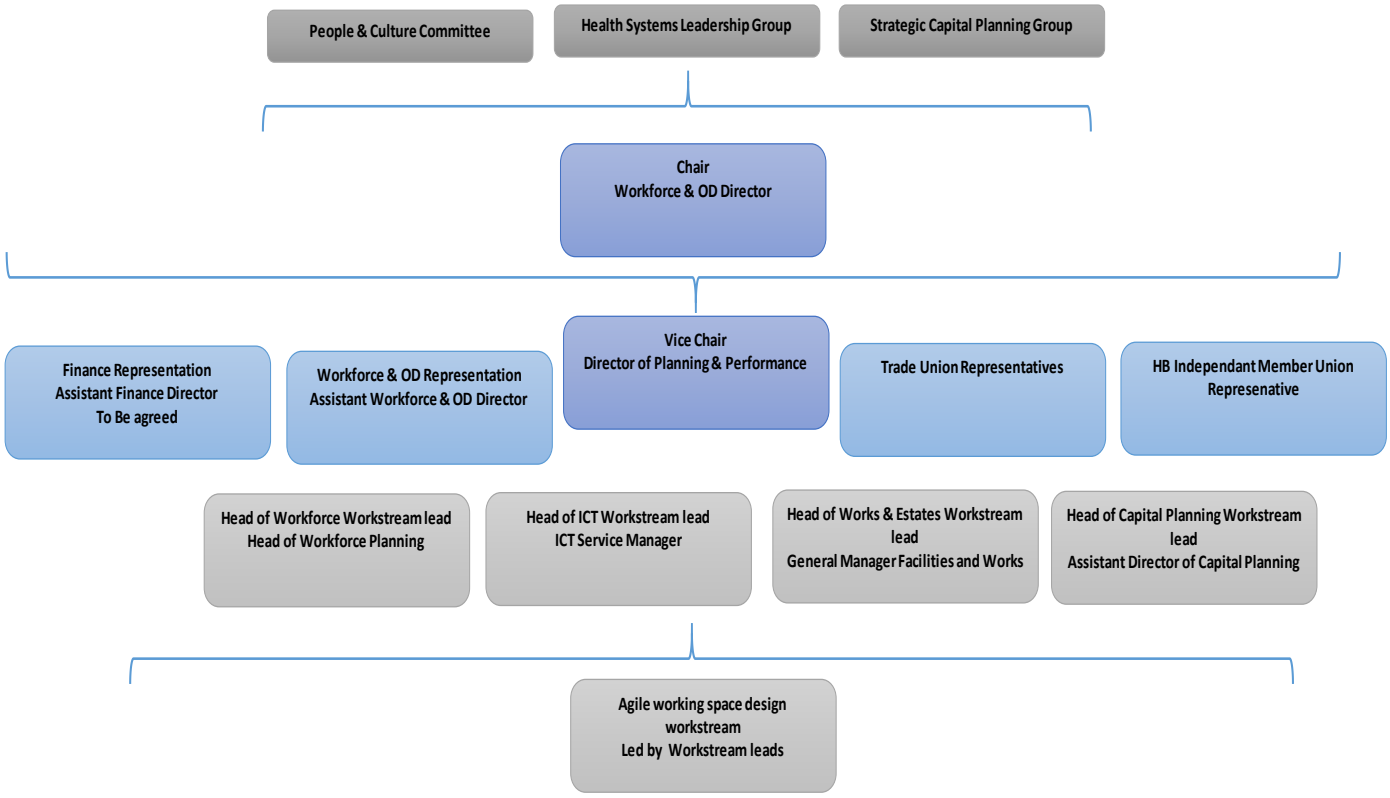
2.7 A range of national documents underpins the Health Board's agile working approach. One of the key aims set by the Welsh Government is that 30% of the workforce can work remotely on a regular basis by 2026. As reported to the People and Culture Committee, previous surveys have shown that 30% of Health Board staff are regularly working in an agile/hybrid way.

2.8 The Welsh Government aims which are set out in their guidance documents are not however, explicitly stated within the Framework and there is no other Health Board policy or document which details them. However, the Health Board does monitor these as there is evidence of reporting on the Welsh Government targets to the People and Culture Committee.

2.9 The Health Board should develop an agile working plan and set out how the Welsh Government targets will be obtained, as there is a risk that progress may be unmonitored. This has been included within **management action two.**

The Plan details SMART objectives and progress of these are monitored by an appropriate forum, with remedial action completed when required

2.10 The Health Board has an Agile Delivery Group (the 'Group'). The Group meets bi-monthly and is chaired by the Director of Workforce and Organisational Development and reports directly to the People and Culture Committee. The Group's purpose is to ensure that there is a programme of work to deliver an organisation that is agile. The structure is illustrated below.



2.11 We reviewed the Group's terms of reference and found that key aspects were not present, including quoracy requirements and meeting frequency. This has been raised as **management action three**.

2.12 Minutes from the Agile Delivery Group confirmed that there is regular oversight of agile working. The Health Board does have a document entitled Programme Plan and this is discussed at each meeting. However, this is not an agile delivery plan, but rather certain tasks that the Health Board is undertaking. For example, assessing opportunities for agile working at designated locations such as Grange House. The Programme Plan should be utilised alongside or incorporated into an overarching agile working plan, to ensure the efforts of the Health Board are focused more effectively. This has been included within **management action two**.

2.13 The Workforce and OD Team, has already undertaken workforce capacity reviews at various sites within the Health Board, including the suitability of the working environment. However, this should be a joint task with other service areas (e.g. Estates, Value Based Healthcare and Finance) to ensure funding and capacity is available. This has been included within **management action two**.

There is effective communication throughout the Health Board to ensure staff are aware of any changes being implemented due to the Plan and staff are consulted on any potential changes.

2.14 Workforce have communicated with staff throughout the Health Board's transition to becoming a more agile organisation. The communication methodology has included:

1. Conducting staff surveys – Three staff surveys have been completed. The surveys covered whether staff thought agile working would be of benefit, what those benefits would be and what challenges exist. Results were positive, with over 77% of staff believing their role allowed for agile working and 87% having a very good experience of agile working.
   The Workforce and OD Team are already aware that survey response rates are low usually only 10-20% and many of the same demographic of staff respond to each survey, thus lowering the usefulness of the data provided. We would advise finding a different way to engage so more staff and from a wider range of divisions can give responses. This has been raised as **management action four.**
2. Conversations between services and the Workforce and OD Team where agile working was being prioritised.
3. Updates on the Intranet – Workforce have recently developed and launched a page for agile delivery on the intranet. The page also contains the new agile / hybrid working framework.
4. Email updates – Updates around agile working and new places to hot desk from are also sent out in emails, e.g. the new hot desking and meeting rooms hub opened at Caerleon House.

Appendix One: Terms of Reference

Scope	Advisory review to assess the Health Board's progress in developing agile working practices and identification of good practice. Objectives of the area under review: 1. There is an Agile Delivery Plan (the 'Plan') in place which has been appropriately approved 2. The Plan has been developed in line with Welsh Government guidance 3. The Plan details SMART objectives and progress of these are monitored by an appropriate forum, with remedial action completed when required 4. There is effective communication throughout the Health Board to ensure staff are aware of any changes being implemented due to the Plan and staff are consulted on any potential changes.
Associated risks	• The Plan has not been developed in line with good practice guidance from the Welsh Government • The Plan does not treat staff in a fair and equitable manner • Planned changes are not adequately managed or controlled resulting in significant issues arising • The Plan is not delivered in a timely manner Health Board staff are unaware of the proposed changes
Limitations to scope	N/A

Appendix Two: What We Did

Our approach was to:

a. undertake a desk-top review of key documents;

b. review and assess the Agile Working plan and governance structure; and

c. interview key staff involved in the Agile Working programme.

To achieve this, we undertook the following review activity:

Interviews with key Health Board staff:	High-level review of:
• Exec Director of Workforce & OD; • Head of Workforce Planning; and • Workforce Planning Manager.	• National guidance on Agile Delivery e.g. Welsh Government documents; • Health Board Flexible Working Policy; • Relevant papers and minutes e.g. Agile Working group agenda and minutes, People and Culture Committee agenda and minutes, Board agenda and minutes, Audit and Risk Committee agenda and minutes; • IMTP; • Estates Strategy; • Agile Working Framework; • Communications between Workforce and staff regarding Agile Working; • Agile Working Intranet page; • Agile Working programme plan; • Agile Working Group Terms of Reference; • Highlight reports; • Agile Working PowerPoint presentation; • Accommodation reviews; and • Agile Working site assessments.

Appendix Three: Recommendations and Management Actions

	Para.	Risk / Potential Impact	D/O[2]	Recommendation	Priority[3]	Agreed Management Action
1		The current Executive Team's vision of agile working has not been considered and therefore the approached to agile working may not be in line with the current vision for the Health Board.	O	Confirm with the Executive Team that the agile working principles noted within the Agile Working Framework still represent the current vision. If amendments are required, the Framework should be updated.	**Low**	An agreed vision for agile working had been agreed by the Executive Team previously and had developed over the response to the COVID pandemic. There are agreed priorities in place for implementing this vision. However, to work beyond the agreed priorities and to embed agile working strategically into Health Board plans it is agreed that this is a good time to re-new the vision. **Responsibility:** **Director of Workforce and OD** **Target Date: November 22**
2		Without a formalised agile working plan, the Health Board is at risk of not being able to identify whether their agile working programme is being delivered effectively across all areas, and / or how its IMTP objectives are being achieved.	D	An overarching agile working plan should be developed. It should include: • An overarching vision (this could be taken from the already published Agile Working Framework). • A set of SMART goals / milestones to achieve this vision. • A list of Welsh Government targets which need to be achieved. • All relevant services areas should be included and engaged with. A benefits list should be developed to sit alongside the plan which details how the Health Board will measure its success against each of the goals. The list should include quantifiable measurements which can be analysed to confirm the success of each goal.	**High**	Agreed, the overarching HB and WG vision will be added to the developed Programme Plan. Overarching SMART goals will be articulated with more specific goals once the assessment and review of the estates has been undertaken. **Responsibility:** **Director of Workforce and OD** **Target Date: November 22**

	Para.	Risk / Potential Impact	D/O[2]	Recommendation	Priority[3]	Agreed Management Action
3		Without an adequate terms of reference, the Agile Working Group may not be fit for purpose, working ineffectively and / or members of the Group may be unaware of their responsibilities.	D	Update the Agile Working Group terms of reference (ToR). The ToR should be updated to include, but not limited to: • The frequency of meetings; and • The quoracy required at meetings.	**Low**	Agreed **Responsibility:** **Director of Workforce and OD** **Target Date: October 2022**
4		The Health Board does not understand how agile working affects their staff and are therefore unable to make the necessary improvements resulting in lower staff retentions rates.	O	The Health Board should engage with staff separately from surveys, for example a more targeted collection of information. Currently, the surveys received a low response rate in certain areas. A different approach to engagement within these areas should be explored and implemented (e.g. site visits).	**Low**	TU / LNC engagement will continue along with Newsletters and specific Departmental meetings to discuss agile working principles and ways of working. This includes sharing of good practice and initiatives in specific areas. Agile discussions and engagement will take place in part under the umbrella of the People First initiative. Other forums will be used dependant on the local context. A delivery plan to support the roll out of the Agile Framework, including communications and engagement, has been developed. **Responsibility:** **Director of Workforce and OD** **Target Date: October 2022**

2. C = Control Design weakness: a gap in the design of the system or process giving rise to increased risk.
   O = Operating Effectiveness issue: non-compliance(s) with the laid down system / process giving rise to increased risk.

3. Recommendation priority rating definitions can be found here.

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

Date issued: October 6, 2022

Document reference: 2813A2022

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

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

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Contents

About this document

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

Accounts audit update

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

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of the 2021-22 Performance Report, Accountability Report and Financial Statements	Complete. The Auditor General certified the Performance Report, Accountability Report, and Financial Statements on 17 June 2022 and were laid before the Senedd the same day.
2021 Audit Plan	Completed; presented to the April Committee meeting.
Audit of Accounts Report	Completed and ISA 260 report presented to the June Committee meeting.
Charitable Funds: • 2021-22 Audit Plan • Audit of Charitable Funds financial statements	Due to prioritisation being given to the audit of the statutory accounts of local government bodies, we are now expecting the planning and the audit of the Charitable Funds financial statements 2021-22 to be undertaken in January 2023. We will confirm dates with the Finance Team in early October.

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

Performance audit update

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

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

Exhibit 2 – Work completed

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

Exhibit 3 – work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit and Risk and Assurance Committee consideration
Structured Assessment 2022	The structured assessment work will build on the baseline governance review by assessing the corporate arrangements in place at the SHA in relation to: • Governance and leadership.	Current Status: Report drafting Planned Date for Consideration: December 2022.

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

Topic and relevant Executive Lead	Focus of the work	Current status and Audit and Risk and Assurance Committee consideration
	then be undertaken on specific elements of unscheduled care pathway, with a likely focus on activities to signpost patients to the most to appropriate care setting, and to manage patient flow through the system.	to start in October 2022. Planned date for consideration: TBC

Exhibit 4 – Planned work not yet started or revised

Topic and relevant Executive Lead	Focus of the work	Current status and Audit, Risk and Assurance Committee consideration
Locally focused work	The precise focus of this work is yet to be determined.	Date for consideration to be confirmed.
All-Wales thematic on workforce planning arrangements	This work will examine the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs. The work will be tailored to align to the responsibilities of individual NHS bodies in respect of workforce planning.	We are currently scoping this work and expect on issuing the project brief in October. We will update the committee as work progresses.

Good Practice events and products

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

6 There have been no Good Practice Exchange (GPX) events since we last reported to the Committee on 2nd August. Details of future events are available on the GPX Website.

NHS-related national studies and related products

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

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

9 The Audit and Assurance Committee might also wish to be sighted of the recently published Audit Wales Strategy - **Assure, Explain, Inspire: Our Strategy 2022-27**. This strategy sets out our 5-year vision to drive improvement and support Welsh public Services as they adapt to the challenges and opportunities of a changing world.

10 We have recently published a national report on the use of Equality Impact Assessments, but the report was not published in time for us to include a link to it in this update. Committee members can find this report on our website www.audit.wales/publications. We will include a link to this in our update for the December committee meeting and request that the Health Board responds where relevant to recommendations made in the report.

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

Title	Publication date
Public Sector Readiness for Net Zero Carbon by 2030: Evidence Report The key messages are summarised in **Appendix 1**	August 2022
Public Sector Readiness for Net Zero Carbon by 2030 **Please see Appendix 1**	July 2022

Appendix 1 – Key messages from recent national publications

Public Sector Readiness for Net Zero Carbon by 2030

11 The Auditor General has committed to a long-term programme of work on climate change. Our baseline review asks: 'How is the public sector preparing to achieve the Welsh Government's collective ambition for a net zero public sector by 2030?'

12 We have now published two reports to share the findings from the baseline review:

- Key findings report: (published 14 July 2022) this report targets senior leaders and those with scrutiny roles, with the aim of inspiring them to increase the pace of their work on achieving the 2030 collective ambition. We set out an overall conclusion and 5 calls for action. The calls for action are not strictly recommendations. However, we encourage public bodies to consider the report, and through their internal governance structures, set out publicly how they intend to respond to the calls for action.
- An evidence report: (published 10 August 2022) this report supplements the key findings report by providing more detailed findings and data. It does not make a separate overall conclusion, or separate calls for action.

13 We have also published blogs and run a successful webinar:

- Responding to the Climate Emergency in Wales (webinar)
- Call for clearer information on climate change spending (blog)
- COP26: Shining a light on the Welsh response to climate change (blog)
- How we'll support Wales in rising to the climate change challenge (blog)
- Heat is on to tackle climate change (blog)

14 The **overall conclusion** from our baseline review is:

15 "There is clear uncertainty about whether the public sector will meet its 2030 collective ambition. Our work identifies significant, common barriers to progress that public bodies must collectively address to meet the ambition of a net zero public sector by 2030. And while public bodies are demonstrating commitment to carbon reduction, they must now significantly ramp up their activities, increase collaboration and place decarbonisation at the heart of their day-to-day operations and decisions. Organisations need to be bold and innovative and share experiences of their successes and failures. The Auditor General will not criticise organisations for taking well-managed risks to address this unprecedented challenge."

16 The **5 calls for action** are:

1 Strengthen your leadership and demonstrate your collective responsibility through effective collaboration

2 Clarify your strategic direction and increase your pace of implementation

3 Get to grips with the finances you need

4 Know your skills gaps and increase your capacity

5 Improve data quality and monitoring to support your decision making

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