

Audit Risk and Assurance Committee

Thu 12 September 2024, 09:30 - 12:00

Microsoft Teams

Agenda

1. Preliminary Matters

 1.0 Audit Risk and Assurance Committee Agenda 12.09.24 Final v1.pdf (3 pages)

1.1. Welcome

Oral Chair

1.2. Apologies for Absence

Oral Chair

1.3. Declarations of Interest

Oral Chair

1.4. Draft Minutes of the last meeting held on 09 July 2024

Attached Chair

 1.4 09_07_2024 Draft Audit Risk and Assurance Minutes - IJ Approved.pdf (11 pages)

1.5. Committee Action Log

Attached Chair

 1.5 09_07_2024 Audit Risk Assurance Committee Action Log - IJ Approved.pdf (3 pages)

2. Items for Approval/Ratification/Decision

2.1. Approve Requested Changes to the Audit Recommendation Tracking Procedure

Attached Director of Corporate Governance

 2.1 Internal and External Audit Recommendations Management Cover Report.pdf (4 pages)

 2.1 Appendix A IA and EA Audit Recommendation Tracking Procedure_v2 post ARAC.pdf (15 pages)

2.2. Approve the Closing Position of the Audit Recommendations Tracking Report; Including a Briefing Note Against the Outstanding Recommendations for 2017 Medical Devices and Equipment Internal Audit

Attached Director of Corporate Governance

 2.2 Internal_External Audit Recommendations Cover Report ARAC.pdf (8 pages)

 2.2 Appendix A 30 Revised Implementation Dates.pdf (1 pages)

 2.2 Appenix B 3 Overdue Recommendations.pdf (1 pages)

 2.2 Appenix C 24 Completed Recommendations.pdf (1 pages)

 2.2 Appendix D 11 Recommendations Requesting a Revised Dealdine over the Agreed Threshold.pdf (1 pages)

 2.2.1 Director of Therapies Health Science_Aditional Information_2017 Audit.pdf (3 pages)

2.3. Approve the Single Use Tender Action

Attached Director of Finance and Procurement

- 📄 2.3 Single Tender Action Report -23.03.2024 - 29.08.2024 .pdf (4 pages)
- 📄 2.3 Single Tender Action 23.03.2024 - 29.08.2024.pdf (2 pages)

2.4. Receive the Report on Financial Governance and Reporting and Ratify Changes to Financial Control Procedures (FCPs)

Attached Director of Finance and Procurement

- Salary Sacrifice FCP
 - Out of Area Referrals do Secondary Care FCP
- 📄 2.4 Governance Report 12.09.2024 .pdf (9 pages)
 - 📄 2.4 Appendix 1 ABUHB_Finance_0883 FCP Salary Sacrifice_Final v5.pdf (12 pages)
 - 📄 2.4 Appendix 2 ABUHB_Finance_0642 Out of Area Referral Policy_Final.pdf (24 pages)

3. Items for Discussion

3.1. Mid-year Report on the Delivery of the Clinical Audit Plan

Attached Assistant Director for Quality and Patient Safety

- 📄 3.1SBAR Final ARA mid year review clinical audit 2024.25.pdf (6 pages)
- 📄 3.1 Appendix A Final ARA 5 month review - Clinical audit Activity 2024.2025.pdf (23 pages)

3.2. Receive a Quarterly Report on Counter Fraud Activity

Attached Head of Counter Fraud

- 📄 3.2 ARAC Counter Fraud Report Q1 2024-25 .pdf (5 pages)

3.3. Review of Committee Programme of Business

Attached Director of Corporate Governance

- 📄 3.3 ARA Committee FWP Cover Report 12.09.24.pdf (4 pages)
- 📄 3.3 Appendix A ARA_Committee Work Programme 2024-25 Final.pdf (6 pages)

3.4. Update on Implementation of the Governance Priorities set out within the IMTP 2022-25

Attached Director of Corporate Governance

- 📄 3.4 Governance Priorities Update_ARAC_Sept 2024docx.pdf (9 pages)

3.5. Update Report on Compliance with Ministerial Directions and Welsh Health Circulars (WHCs)

Attached Director of Corporate Governance

- 📄 3.5 Compliance with Ministerial Directions and Welsh Health Circulars Sept 2024.pdf (6 pages)
- 📄 3.5 Appendix A Compliance Dashboard .pdf (1 pages)
- 📄 3.5 Appendix B Compliance with Welsh Health Circulars 2024.pdf (4 pages)
- 📄 3.5 Appendix C Compliance with Welsh Health Circulars 2023 .pdf (5 pages)
- 📄 3.5 Appendix D Compliance with Ministerial Directions .pdf (4 pages)
- 📄 3.5 Appendix E Compliance Welsh Health Circulars 2022 .pdf (4 pages)

3.6. Committee Risk & Assurance Report

Attached Director of Corporate Governance

- 📄 3.6 Strategic Risk and Assurance Report Cover Report_Sept 2024.pdf (9 pages)
- 📄 3.6 Appendix A Strategic Risk Register.pdf (28 pages)

3.7. Receive Internal Audit Progress Report

Attached

Head of Internal Audit

 3.7 ABUHB September 2024 Audit Committee Progress Report.pdf (7 pages)

3.8. Receive Internal Audit Reports

Head of Internal Audit

3.8.1. Reasonable Assurance - Financial Savings

Attached

 3.8.1 ABUHB 2324-1 Savings Programmes Final Internal Audit Report.pdf (12 pages)

3.8.2. Reasonable Assurance - Waiting List Management

Attached

 3.8.2 ABUHB 2023.24 Final Waiting List Management Audit Report.pdf (24 pages)

3.8.3. Reasonable Assurance - Regional Radiotherapy Satellite Centre

Attached

 3.8.3 ABUHB_2324-SSU_Final Report.pdf (29 pages)

3.9. Receive External Audit Progress Report

Attached

Performance Audit Lead, Audit Wales

 3.9 Audit Risk and Assurance Committee Update - September 2024.pdf (14 pages)

4. Items For Information

Chair

4.1. Chairs of Audit Committees Operating Arrangements

Attached

 4.1 Chairs of Audit Committees Operating Arrangements Final .pdf (3 pages)

4.2. National KPI Template for Capital Projects

Attached

 4.2 NHSBfW KPI LHB Perform forms Incl PBAs.pdf (7 pages)

4.3. Response from Welsh Government on the Questions set out in the Audit Wales Community Pharmacy Data Matching Report

Attached

 4.3 Pharamcy Resposne MA_EM_5960_24 Annex 3 revised.pdf (4 pages)

5. Other Matters

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

Oral

Chair

5.2. Any Other Urgent Business

Oral

Chair

5.3. Date of the Next Meeting - Tuesday 12 November 2024

Oral Chair

Agenda Setting Meeting - Tuesday 08 October 2024

AUDIT, RISK & ASSURANCE COMMITTEE AGENDA

Date and Time

Tuesday 12th September at 09:30

Venue

Microsoft Teams

Item	Title	Format	Presenter
1	PRELIMINARY MATTERS		
1.1	Welcome and Introductions	Oral	Chair
1.2	Apologies for Absence	Oral	Chair
1.3	Declarations of Interest	Oral	Chair
1.4	Draft Minutes of the last Meeting held on 09 July 2024	Attached	Chair
1.5	Committee Action Log and Matters Arising	Attached	Chair
2	ITEMS FOR APPROVAL/RATIFICATION/DECISION		
2.1	To Approve Requested Changes to the Audit Recommendation Tracking Procedure	Attached	Director of Corporate Governance
2.2	To Approve the Quarter 2 2024/25 Closing Position of the Audit Recommendations Tracking Report, to include; A Briefing Note against the outstanding recommendations for 2017 Medical Devices and Equipment Internal Audit	Attached	Director of Corporate Governance
2.3	To Approve the Use of Single Tender Action	Attached	Director of Finance and Procurement
2.4	To Receive the Report on Financial Governance and Reporting and Ratify Changes to Financial Control Procedures (FCPs) - Salary Sacrifice FCP - Out of Area Referrals to Secondary Care FCP	Attached	Director of Finance and Procurement



3 ITEMS FOR DISCUSSION			
3.1	Mid-year Report on the delivery of the Clinical Audit Plan	Attached	Assistant Director for Quality & Patient Safety
3.2	Receive a Quarterly Report on Counter Fraud Activity	Attached	Director of Finance and Procurement
3.3	Review of Committee Programme of Business	Attached	Director of Corporate Governance
3.4	Receive Assurance on Implementation of the Governance Priorities set out within the IMTP 2022-25	Attached	Director of Corporate Governance
3.5	Compliance with Ministerial Directions and Welsh Health Circulars (WHCs)	Attached	Director of Corporate Governance
3.6	Committee Risk & Assurance Report	Attached	Director of Corporate Governance
3.7	Receive Internal Audit Progress Report	Attached	Head of Internal Audit
3.8	Receive Internal Audit Reports Reasonable Assurance - Waiting List Management - Financial Savings - Regional Radiotherapy Satellite Centre	Attached	Head of Internal Audit
3.9	Receive External Audit Progress Report	Attached	Performance Audit Lead, Audit Wales
4 ITEMS FOR INFORMATION			
4.1	Chairs of Audit Committees Operating Arrangements	Attached	Chair
4.2	National KPI Template for Capital Projects	Attached	Chair
4.3	Response from Welsh Government on the Questions set out in the Audit Wales Community Pharmacy Data Matching Report	Attached	Chair
5 OTHER MATTERS			



5.1	Items to be Brought to the Attention of the Board and Other Committees	Oral	Chair
5.2	Any Other Urgent Business	Oral	Chair
5.3	Date of the Next Meeting: Tuesday 12 November 2024 (Agenda setting Tuesday 08 October 2024)		

Motion to Exclude Members of the Public and the Press

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





**GIG
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NHS
WALES** | Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

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

MINUTES OF THE AUDIT RISK & ASSURANCE COMMITTEE

DATE OF MEETING	Tuesday 09 July 2024
VENUE	Microsoft Teams

PRESENT	Iwan Jones - Independent Member, Committee Chair Dafydd Vaughan - Independent Member Neil Patrick – Independent Member
IN ATTENDANCE	Nicola Prygodzicz – Chief Executive (<i>left at 10:30</i>) Rani Dash - Director of Corporate Governance Rob Holcombe - Director of Finance and Procurement Estelle Evans - Head of Financial Services & Accounting Nicola Tillings – Interim Head of Counter Fraud (<i>left at 10:05</i>) Bryony Codd – Head of Corporate Governance (<i>left at 11:00</i>) Tracy Daszkiewicz – Director of Public Health (<i>joined at 11:00 – left at 11.15</i>) Sarah Simmonds - Director of Workforce & OD (<i>left at 10:50</i>) Julie Chapelle - Assistant Director of Workforce (<i>left at 10:-:50</i>) Hannah Capel – Assistant Director Strategic Capital (<i>joined at 11:00 – left at 11.15</i>) Stephen Chaney –Head of Internal Audit (<i>joined at 10:15</i>) Sara Utley – Performance Audit Lead, Audit Wales Julie Rees – Finance Audit Manager, Audit Wales Angharad Clements – Auditor, Audit Wales (<i>left at 10:35</i>) Lucy Windsor – Head of Corporate Risk and Assurance (Secretariat)
Apologies	Richard Clark– Independent Member, Committee Vice Chair

ARAC 0907/1	Preliminary Matters
ARAC 0907/1.1	Welcome and Introductions The Chair welcomed everyone to the meeting.
ARAC 0907/1.2	Apologies for Absence Apologies were noted.
ARAC 0907/1.3	Declarations of Interest There were no declarations of interest raised to record.



ARAC 0907/1.4	Minutes of the previous meeting The minutes of the meeting held on the 22 May 2024 were agreed as a true and accurate record.
ARAC 0907/1.5	Committee Action Log The Committee reviewed the action log, noting actions completed, actions in progress, and actions not yet due. Rob Holcombe (RH), Director of Finance, recommended that Action ARAC 2105/3.4 Infected Blood Inquiry be completed. He noted that the action had been discussed with Audit Wales and that the accounts had already included the necessary information in respect of any costs incurred. The Committee AGREED that completed actions could be removed from the Action Log.
ARAC 0907/1.5.1	Job Planning Assurance Note Sarah Simmonds (SS), the Director of Workforce & OD, and Julie Chapelle (JC), the Assistant Director of Workforce, attended the meeting on behalf of the Medical Director. They were there to address any questions or concerns regarding the Assurance Note provided. The Committee raised concerns about the job planning compliance target, emphasising that the aim should be 100% compliance with exceptions. SS had stated that the national target for compliance was 85%, aligning with the PADR target designed for staff on extended periods of leave. JC had indicated that the plan going forward was to achieve the 85% goal by the end of the year. In areas where there was no long-term absence but still not 100% compliance, targeted intervention would be implemented. It was agreed that the Committee would receive detailed updates on progress towards full compliance.
ARAC 0907/2	ITEMS FOR APPROVAL / RATIFICATION / DECISION
ARAC 0907/2.1	Closing Position for Q1 2024/25 Audit Recommendations Rani Dash (RD) Director of Corporate Governance provided the Committee with an update on the audit recommendations as of 30 June 2024. RD requested approval of the closing position of the 109 recommendations outlined below: • 42 recommendations sought revised deadlines, • 9 recommendations had been completed, • 8 recommendations remained overdue.



	Concerns were raised regarding recommendations that had been repeatedly delayed and revised. The Committee requested that any recommendations requiring more than two revised deadlines should be accompanied by a detailed assurance report. RD agreed to include detailed assurance reports as an appendix in future reports for any recommendations that required an extension to the deadline, exceeding the threshold of two previous requests. In addition, would request additional information from the Executive Leads regarding the status of the eight that remained outstanding, as well as the two high priority recommendations related to the 2017 Medical Devices report and circulate to the Committee. ACTION: Head of Corporate Risk and Assurance The Committee APPROVED the closing position of the Completed recommendations. In respect of the revised deadlines the Committee APPROVED all requests except for the two high priority medical devices on the basis that they were high priority from 2017 and had been 4 times previous requests to the deadline. The committee sought further assurance to understand the issues encountered in closing the actions.
ARAC 0907/2.2	Audit Recommendation Tracking Procedure Rani Dash (RD), the Director of Corporate Governance, presented the Committee with the updated Audit Recommendation Tracking Procedure. She mentioned that the procedure had been revised due to concerns regarding audits that had involved multiple directors. The Procedure had been strengthened to ensure a more rigorous end-to-end process, which included the handling of management responses and audits to ensure quality assurance and a robust sign-off process. There was a request to add additional wording on page 6 of the procedure 'management responses' to address the prevention of future occurrences. ACTION: Director of Corporate Governance / Head of Corporate Risk and Assurance The Committee sought clarification on how the Health Board addressed audit points on the tracker that are beyond its scope, specifically those related to national audits such as IT. While there was an appetite to include those recommendations in the Tracker for awareness, it was agreed that a more effective approach was necessary, to avoid unnecessary monitoring. RD agreed to discuss with Internal and External Audit and for the Procedure to include a mutually agreed approach. The



	Procedure would come forward to the next Committee meeting for approval of the inclusions. ACTION: Director of Corporate Governance The Committee APPROVED the Audit Recommendation Tracking Procedure in principle but would officially sign it off following the inclusion of the actions agreed.
ARAC 0907/2.3	Capital Assets and Charges FCP Rob Holcombe (RH), Director of Finance, informed the Committee of the changes to the Capital Assets and Charges FCP, stating that the changes were in response to internal audit recommendations. The process had been updated to include divisional general managers signing off on asset disposal forms, resulting in greater ownership and control over delegated assets. The Committee was informed that most of the audit's untracked assets had been resolved, leaving only two with a net book value of under £4k. The remaining items were identified through disposal procedures and team discussions. The Chair suggested that any asset sales be notified and approved by the Finance team prior to the transaction. RH would consider the request for a future iteration of the FCP. The Committee APPROVED changes to the Capital Assets and Charges FCP.
ARAC 0907/3	ITEMS FOR DISCUSSION
ARAC 0907/3.1	Counter Fraud Functional Standard Return Declaration Nicola Tillings (NT), Interim Head of Counter Fraud presented the report. The Committee noted the positive counter fraud performance report, which showed a successful year with good levels of recoveries. NT stated that work would continue to manage new referrals with a stronger focus on the comprehensive risk assessment process across all at-risk areas within the Health Board. The Committee ENDORSED the Counter Fraud Functional Standard Return Declaration
ARAC 0907/3.2	Post Payment Verification Annual Report 2023/24 Amanda Legge (AL) Post Payment Verification Manager presented the Committee with the Annual Report and proposed work programme for 2024/24.



	An additional modification to the Medical Pay award was noted, however due to the timing the amendment it would not affect the 2023/24 accounts but would be reflected in the 2024/25 final annual accounts. There was a discussion concerning the Bevan Health and Wellbeing Centre project, particularly its impairment charges and two limited internal audit reports. It was proposed that a thorough evaluation be undertaken to understand the impairment charges and learn from the difficulties encountered, especially with the supply chain partner. Nicola Prygodzicz (NP), CEO, suggested a deep dive and utilising the Welsh Government's gateway reviews to apply lessons learned to future projects. Further scrutiny would be referred to the Finance and Performance Committee. ACTION: Secretariat The Committee thanked the Finance Team and Audit Wales for their significant contribution in developing and finalising the accounts. The Committee NOTED the report and ENDORSED the Final Accounts for Board Approval.
ARAC 0907/3.6	Audit of Accounts (ISA 260) including Letter of Representation Julie Rees (JR), Finance Audit Manager, Audit Wales provided an overview of the Audit of Accounts noting Audit Wales intended to issue an unqualified financial statement opinion. The regularity opinion would be qualified due to the Health Board's failure to achieve its three-year break-even target. The three-year deficit, which encompassed adjustments, was £86.359m. The committed NOTED the report.
ARAC 0907/3.7	To Agree a Recommendation to the Board in respect of the audited annual report and accounts The Audit, Risk and Assurance Committee recommended that the Board: • RECEIVE the Audit Wales Audit of Accounts Report (2023/24) • APPROVE the Annual Report and Accounts 2023/24, which includes: 1. The Performance Report; 2. The Annual Accountability Report; and 3. The Financial Statements • APPROVE the Letter of Representation; and



	• AUTHORISE the Chair, Chief Executive Officer, and Director of Finance & Procurement, to sign the documents where required.
ARAC 0907/3.8	External Audit Progress Report 2024/25 Sara Utley (SA), Audit Wales, presented the Committee with an overview of the 2024/25 External Audit progress report. The Committee was informed that the Charitable Funds Audit was scheduled for November with the intention of completing mid-December. The Committee NOTED the report.
ARAC 0907/3.9	Audit Wales Community Pharmacy Data Matching Report Sara Utley (SU), Audit Wales, provided a summary of the report, highlighting that the pilot examined community pharmacy risks, particularly those associated with expensive items, specials, and higher-cost formulations. While the pilot yielded valuable data, it was decided that neither the pilot nor the tool would be implemented. No recommendations were issued but three questions were posed to evaluate health board's current practices and to promote improvements in community pharmacy spending and cost reduction. Rob Holcombe (RH), Director of Finance, agreed to contact the Health Board's Lead for Medicines Management and request that the Health Board's responses to the three questions be presented at a future Committee meeting to discuss how the Health Board intended to address the concerns raised. ACTION: Director of Finance / Secretariat The Committee NOTED the Report.
ARAC 0907/3.10	Head of Internal Audit Opinion 2023/24 The Committee was informed that the Head of Internal Audit Opinion Annual Report 2023/24 concluded with Reasonable Assurance, noting 27 audits had been completed with 5 concluding Limited Assurance. Progress was noted against key risk areas, showing positive control within completed work, and governance arrangements were strengthened, establishing a more robust control framework across the Health Board. The Committee NOTED the Report
ARAC 0907/3.10.1	Internal Audit Progress Report including 2024/25 Internal Audit Work Plan Stephen Chaney (SC), Head of Internal Audit, provided a summary of the Internal Audit Progress Report noting all audits



	for 2023/24 had been completed and work had started on the 2024/25 audit plan. Rob Holcombe (RH), the Director of Finance, queried the Health Board's involvement in internal audits of Shared Services and broader organisational structures. He suggested conducting a follow-up payroll management audit of Shared Services to ensure the accuracy of payments. Additionally, he highlighted the importance of a follow-up review of the Joint Commissioning Committee (JCC). Rani Dash (RD), Director of Corporate Governance, informed the Committee that work was ongoing in respect of the governance structure in relation to the host body and the JCC and highlighted the appointment of a Transition Director to assist with embedding the new arrangements. The Committee NOTED the Internal Audit Progress Report and the 2024/25 Internal Audit Work Plan for Assurance.
ARAC 0907/3.11	To Receive Internal Audit Reports Stephen Chaney (SC) - Head of Internal Audit, provided the Committee with an overview of the following reports. Bevan Health and Wellbeing Centre – Limited Assurance The Chair raised concerns about recurring issues in projects and sought assurance that these issues would not persist in future projects. Hannah Capel (HC) Assistant Director of Strategic Planning reassured the Committee by informing them of the new approach being implemented to standardise and track capital project management going forward and the introduction of sanctions for poor performing contractors. The Committee requested that a set of local KPIs should be introduced alongside national KPIs in order to prevent occurrence of historical issues. Regional Partnership Board (RPB): Financial Controls Limited Assurance SC highlighted the current processes and challenges in handling payments by the Health Board on behalf of the RPB. Despite adherence to Health Board SFIs and thorough testing ensuring proper transaction handling, the non-standard nature of certain transactions and unclear procedural definitions had caused issues. The cessation of advance payments and the progression of a Memorandum of Understanding with the RPB, along with the



Health Board commissioned governance review, all aimed to clarify roles, responsibilities, and procedures. These steps were expected to enhance alignment, transparency, and efficiency in financial processes moving forward.

Decarbonisation – Limited Assurance

The Committee was informed that governance structures, initiatives, and decarbonisation awareness had improved but achieving the mandated level of decarbonisation remained challenging without adequate funding and supportive measures. The Committee questioned the management response to recommendation 3C, particularly the Health Board's initial non-agreement and its impact on Wellbeing of Future Generations Act compliance. RH explained that financial constraints prevented the comprehensive plan from using external consultants. He acknowledged that the REFIT programme could be an opportunity to improve energy efficiency and decarbonisation.

RH agreed to change the Health Board's response to "agreed in principle" instead of "not agreed," indicating ongoing consideration of the audit recommendation and a willingness to reassess the decision as circumstances permit.

ACTION: Head of Internal Audit

LINC Programme - Reasonable Assurance

The Committee expressed concern about the challenges regarding the LINC programme and its associated risks in recognition of the multiple projects and the Health Board's capacity to manage the multiple concurrent projects. This was followed up with further concerns surrounding the lack of Health Board involvement in the planning and design phase which could impact functionality and overall project progress.

The Committee requested a detailed report be scheduled for a future Committee meeting to better understand the status of the programme and address the concerns raised. Rani Dash (RD) requested that the concerns be raised at the Board meeting on 17 July 2024 with a request for a detailed report to be provided to the Committee.

Intra-Site Patient - Reasonable Assurance

The Committee noted the report. No questions or concerns were raised.

Theatres (Stock) - Reasonable Assurance

RH raised a concern regarding Recommendation 3.1, specifically the scope of reporting which was confined to the spending area



	and emphasised the necessity for broader scrutiny and oversight, particularly at the Directorate Management Team level. He noted that even seemingly minor discrepancies could have significant financial implications and suggested a follow-up review would be beneficial. In addition, he suggested that the response be revisited to include a more detailed approach that could potentially enhance its effectiveness. SC agreed to either use the follow-up of high-priority recommendations to review processes or conduct a follow-up review later in the 2024/25 audit year. Financial Controls – Substantial Assurance The Committee noted the report. No questions or concerns were raised. Flexible Working - Advisory The Committee noted the report. No questions or concerns were raised. The Committee NOTED the audit reports for Assurance.
ARAC 0907/3.12	Committee Risk & Assurance Report Rani Dash (RD) Director of Corporate Governance presented the Committee with an overview of the Risk and Assurance Report. The Chair questioned the effectiveness of actions in reducing the strategic risks. RD acknowledged the concerns and stated the actions being taken are effectively addressing the risks, but given the nature of the risks, scores and risk levels won't necessarily reduce quickly. However, the Committee should be able to a reasonable level of assurance that the actions are mitigating the risks' likelihood and consequences. The Committee NOTED the Report for Assurance.
ARAC 0907/3.12	Committee Programme of Business Rani Dash (RD) Director of Corporate Governance presented the Committee with an overview of the Forward work Programme and noted the Committee was on track in receiving updates against its delegated areas of responsibility. The Committee NOTED the Report for Assurance
ARAC 0907/4	Items for Information
	Nothing Received.
ARAC 0907/5	Other Matters
ARAC 0907/5.1	Items to be Brought to the Attention of the Board and Other Committees



	Finance and Performance Committee to receive a report on impairment charges for the Bevan Health & Wellbeing Centre and lessons learnt (including items raised from the 2 limited audits).
ARAC 0907/5.2	Any Other Urgent Business Nothing reported.
ARAC 0907/5.3	Date of the next meeting; Tuesday 02 September 2024

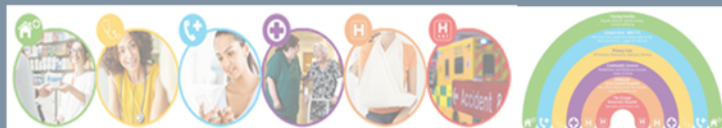
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BEVAN**

**Audit Risk and Assurance ANEURIN BEVAN UNIVERSITY
HEALTH BOARD MEETING**

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
July 2024	ARAC 0907/1.5.1 Job Planning Assurance Note	An update on the progress of Consultant Job Plans is to be received. The report should include the number of plans recorded in the system, demonstrate progress against the target, and outline any challenges. Where there are areas of low compliance, the report should also detail the interventions implemented to address these issues.	Medical Director / Director of Workforce and OD	12 November 2024	Not Due.
July 2024	ARAC 0907/2.2 Audit Recommendation Tracker	In future reports, include an appendix for any recommendations that exceed two previous deadline extensions. This appendix should provide detailed explanations for why the recommendation has not yet been implemented	Head of Corporate Risk and Assurance Head of Corporate Risk and Assurance	02 September 2024	Outstanding. To be implemented for November reporting.
		Request additional information from the Executive Leads regarding the position of the 8 recommendations that remained outstanding for circulation to the		2 weeks from ARAC meeting (23 July)	Partially Completed. A briefing note has been included as item 2.1.1



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

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		Committee as well as enhanced assurance for the two high priority medical devices (2017) recommendations.			regarding the high-priority recommendations from the 2017 Medical Devices Audit. Following the agreed position at the September meeting, additional information will be requested for any outstanding recommendations or those with more than two revised deadlines. This information will be circulated to the Committee.
July 2024	ARAC 0907/3.5 Final Accounts	Refer to the Finance and Performance Committee the Committees request to receive a detail report on Impairment Charges linked to Capital programmes, specifically the Bevan Health & Wellbeing Centre. The report to include lessons learnt for future projects.	Secretariat	2 weeks from ARAC meeting (23 July)	Completed. Transferred to the Finance and Performance Committee



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

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
July 2024	ARAC 2105/3.7 Internal Audit Reports	To agree with Internal and External Audit the approach for monitoring recommendations outside of the Health Board's remit to implement. The outcome to be included in the procedural document.	Director of Corporate Governance	12 September 2024	Completed Approach included in the procedure.
July 2024	ARAC 0907/3.9 Audit Wales Community Pharmacy Data Matching Report	The Medicines Management Lead to be contacted to attend and present the Health Board's response to the questions posed in the report should be presented to the Committee to clarify how the Health Board intends to address the issues raised.	Secretariat	12 November 2024	Completed. The Director of Pharmacy advised that the response was a central response from the Welsh Government to Audit Wales and is included as Item 4.3 for information.
July 2024	ARAC 0907/3.11 Internal Audit Reports	Decarbonisation Audit Report - change the Health Board's response to "agreed in principle" instead of "not agreed," indicating ongoing consideration of the audit recommendation.	Head of Internal Audit	2 weeks from ARAC meeting (23 July)	Completed. The wording has been amended.

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

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





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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	12 September 2024
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Procedure for Receiving, Finalising and Managing Internal and External Audit Reports and Recommendations
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Corporate Risk and Assurance

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

Ar Gyfer Trafodaeth/For Discussion

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The paper is presented to the Audit, Risk and Assurance Committee (the Committee) for approval of the changes requested during the July meeting.

Cefndir / Background

In the July meeting, the Committee requested clarification on how the Health Board addresses audit points that fall beyond its scope, particularly those related to national audits or workstreams that cannot progress until national systems and processes are implemented.

Asesiad / Assessment

The draft internal process, attached as **Appendix A**, includes the requested updates, highlighted in red, which are detailed below:

- **Management Response:** Added wording focused on preventing future recurrence of issues.

- **Out-of-Scope Recommendations:** Added narrative explaining how recommendations from audits that are beyond the local organisation's scope are managed in the relevant sections of the document.

For ease of understanding how out-of-scope recommendations will be managed, the approach is set out below.

To manage out-of-scope recommendations effectively, it is essential to determine early on whether these recommendations can be implemented solely by the Health Board or if they require third-party involvement, which is beyond the Health Board's direct control. This distinction should be communicated clearly to both auditors and the Committee, ensuring that all parties are aware of the scope limitations.

For out-of-scope recommendations originating from national thematic reviews or audits, these should be documented in the Tracker with a management response that acknowledges the recommendation and outlines the limitations regarding its implementation. To differentiate them from actionable items, these out-of-scope recommendations will be listed on a separate sheet within the Tracker.

The Committee will be updated on out-of-scope recommendations in the following scenarios:

Scenario 1: If the implementation of local recommendations has stalled due to delays in national progress beyond the expected timeframe, this issue should be highlighted in the Audit Tracking Report to the Committee. The Committee will then decide if escalation to the third-party organisation through the Health Board is necessary.

Scenario 2: When only one recommendation remains against an audit report, the Head of Corporate Risk and Assurance will cross-check this recommendation against the out-of-scope recommendations log in the Tracker to identify any related recommendations. A status update will be requested from the Executive Director concerning these out-of-scope recommendations to ensure completeness and accuracy.

The updates will be reported to the ARA Committee, providing a clear audit trail and either indicating any barriers to implementation or confirming that all recommendations have been fully addressed. Following the Committee's approval, recommendations that have been completed will be transferred to the completed log, while those still in progress will remain on the Tracker until they are fully resolved.

This approach ensures effective management, clear communication, and transparency in the implementation of all recommendations arising from assurance work. By systematically documenting and tracking out-of-scope recommendations, differentiating them from actionable items, and providing detailed updates to the Committee, the process upholds accountability and provides a clear audit trail.

Additionally, a section on Escalation has been included in the document, even though it was not explicitly requested by the Committee. This section highlights the importance of expediting the completion of audit reports to ensure timely circulation of audit papers. However, it also includes caveats to promote a balanced and proportionate use of the escalation process. This ensures that while there is an emphasis on timeliness, the process remains judicious and appropriate, addressing significant delays or issues without compromising the thoroughness and fairness of the review process.

The changes implemented facilitate proactive resolution of delays, ensure accurate reporting of progress, and provide assurance that all recommendations are addressed appropriately.

The updates were communicated to both Internal and External Audit colleagues, who expressed their support for the enhanced arrangements.

Argymhelliad / Recommendation

The Committee is asked to: -

- **DISCUSS** and **APPROVE** the enhanced governance arrangements.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Audit recommendations inform risk.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. N/A
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:

Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Executive Committee

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



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Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

PROCEDURE FOR THE MANAGEMENT OF INTERNAL AND EXTERNAL AUDIT RECOMMENDATIONS

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1. PURPOSE

The purpose of this Procedure is to set out the:

- requirement to have a comprehensive and considered management response and action plan in response to Internal and External Audit Reviews (signed off by the lead Executive Director);
- requirement for management responses and action plans to facilitate scrutiny and provide assurance that actions have been implemented in a robust and timely way;
- the role of the Audit, Risk & Assurance Committee in:
 - receiving final Internal and External reports, alongside management responses and action plans;
 - being assured of the adequacy of the management response to issues identified by internal and external audit and the arrangements for monitoring respective actions going forward;
 - challenging the pace of delivery of actions and approving any changes to the agreed timescales of actions;
 - agreeing the frequency of monitoring based on the level of risk and priority of actions; and
 - overseeing the closure of action plans;
- requirement to have one central point for the receipt, logging, tracking, monitoring and reporting of progress against internal and external audit reviews and associated recommendations.

This procedure does not extend to the management of improvement actions arising from regulatory inspections or independent reviews (such as those conducted by Llais). The nature of which is handled separately and overseen by the Board's Patient Quality, Safety, and Outcomes Committee.

2. ROLES AND RESPONSIBILITIES

The Role of the Board in Respect of Internal and External Audit

As set out within Standing Orders, the Board is expected to set out explicitly, within a Risk and Assurance Framework, how it will be assured on the conduct of Health Board business, its governance and the effective management of the organisation's risks in pursuance of its aims and objectives. The Board shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

In doing so, the Board shall ensure that its assurance arrangements are operating effectively, advised by its Audit, Risk & Assurance (ARA) Committee.

The Board shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards.

The Board will also seek assurance from the work carried out by external audit on the adequacy of the Health Board's assurance framework. However, that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the Board itself may commission specifically for that purpose.

The Role of the Audit, Risk & Assurance (ARA) Committee

The Codes of Conduct and Accountability for NHS Boards and the Code of Conduct for NHS Managers Directions 2006 [WHC (2006) 090] establishes the requirement for every NHS Board to establish an Audit Committee, and this has been incorporated into Standing Orders for Local Health Boards. At its meeting on 23rd March 2022, the Board reviewed its Committee structure and approved the establishment of the ARA Committee, which can be found [here](#).

The ARA Committee supports the Board by critically reviewing governance and assurance processes on which the Board places reliance. At the corporate level these will include a risk management system and a performance management system underpinned by an effective system of assurance.

The ARA Committee's primary role is to ensure the system of assurance is valid and suitable for the Board's requirements. The ARA Committee will review whether:

- The system of assurance is appropriate for the organisation;
- Processes to seek and provide assurance are robust and relevant;
- The controls in place are sound and complete;
- Assurances are reliable and of good quality; and
- Assurances are based on reliable, accurate and timely information and data.

In fulfilling its role, the ARA Committee will rely on the organisation's internal arrangements and consider any audit work.

The Role of Internal Audit

Internal Audit is a key source of independent internal assurance to the Board and Accountable Officer (Chief Executive Officer). The Public Sector Internal Audit Standards ([PSAIS 1 April 2017.pdf \(publishing.service.gov.uk\)](#))

describe the role of internal audit as enhancing and protecting organisational value by providing risk-based and objective assurance, advice and insight.

As such, its role embraces two key areas:

1. The provision of an independent and objective opinion (the Head of Internal Audit Opinion) to the Accountable Officer, the Board, and the ARA Committee based on an objective assessment of the framework of governance, risk management and control; and
2. The provision of an independent and objective advisory service, with the aim of supporting management to improve governance, risk management and control and contributing to the overall opinion of the Head of Internal Audit.

The Public Sector Internal Audit Standards provide an essential reference source for the ARA Committee in understanding what it can expect from internal audit and when assessing the service provided.

To support the system of assurance, Internal Audit will develop a risk based annual internal audit plan which details all the audit reviews to be undertaken in the coming financial year.

The Role of External Audit

The Auditor General for Wales (the Auditor General) is the external auditor of NHS Wales. The statutory duties of the Auditor General in respect of individual NHS bodies fall under two broad headings – to review and report on:

- The audited body's financial statements, and on its Annual Governance Statement; and
- Whether the audited body has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

The external audit role is exercised in accordance with statutory provisions and the work of external auditors is subject to the 'Code of Audit Practice of the Auditor General for Wales' ([Code of Audit Practice | Audit Wales](#)) and 'the Statement of the responsibilities of the Auditor General for Wales and of the bodies that he or she audits'.

The Auditor General's representatives (the External Audit Team) will develop an annual audit plan designed to deliver a safe opinion on the accounts and to enable the Auditor General to draw conclusions on whether the NHS body has made proper arrangements for securing economy, efficient and effectiveness in its use of resources.

The audit plan will also cover issues such as regularity, propriety and value for money.

In developing the annual audit plan the Auditor General's representatives will consider the audit needs of the organisation, using a risk-based approach.

3. MANAGEMENT AND TRACKING OF AUDIT REPORTS

Internal and External Audit – Audit Scope

The Annual Audit Plans will detail the audit assignments, lead executive officers, scopes, and proposed timelines. Before each audit, the responsible executive director(s) will receive a draft audit brief outlining the scope, objectives, audit resource requirements, and timing.

Once both parties have agreed on the draft brief, a final copy of the audit will be issued before fieldwork begins.

At this point in the audit process, the office of the Corporate Governance Director (Director of Corporate Governance and the Head of Corporate Risk and Assurance) should be copied in to ensure awareness.

Internal and External Audit Outcome Reports and Management Responses/Action Plan

For each review in both the internal and external audit plans, an audit report will be issued which includes an assurance opinion on how effective the internal controls are in the scope of that review.

Draft reports will be issued to the Health Board via the Corporate Governance Director's office to ensure process consistency and that the report is distributed to the Lead Director(s) and key stakeholders. The Head of Corporate, Risk and Assurance will distribute on behalf of the Director of Corporate Governance.

The Lead Executive should use the draft report clearance process to highlight for the attention of auditors any concerns they have about the wording, practicality or relevance of audit recommendations, this part of the process will remain between the Lead Director(s) and auditors. The Director of Corporate Governance will support discussion between the Lead Director (s) and auditors where appropriate.

When developing the management response and action plan, management must ensure consideration is given to the capacity and costs required to deliver the actions and any associated risks, ensuring value for money. Where actions require capital investment, consideration also must be given to managing the risk in the interim as capital funding to enable progress may not be available within the timescales committed to in the management response. In these circumstances, other action should be taken to manage the risk which must also be detailed in the action plan and, where appropriate, be added to operational risk registers.

Management responses must: -

- Respond directly to the finding and its recommendation(s);
- Provide specific actions that the Health Board commits to take to correct the finding and to prevent future reoccurrence;
- Exclude information that is not pertinent to the finding or its corrective action plan;
- Identify a specific individual for the implementation of an action;
- Provide a specific and realistic timetable for implementation; and
- Be SMART (Specific, Measurable, Achievable, Realistic, with a clear timeframe);
- Approved by the relevant Executive Director prior to finalising with internal or external audit

There may also be occasions where recommendations fall outside the gift of the division/directorate/service/team audited to implement and therefore other functions within the Health Board, for example corporate teams such as IT or Estates, will be required to develop appropriate actions for management responses, and be responsible for the delivery of these.

It is crucial to determine early on whether the recommendations can be implemented solely by the Health Board or if implementation depends on third-party involvement and is therefore beyond the Health Board's direct control. Such situations should be clearly communicated to both auditors and the Committee and formally documented in tracking database updates. For instance, if national thematic reviews or audits produce findings or recommendations that apply to all health bodies or the Health Board alone but are beyond the scope of local bodies or the Health Board to implement, they should be included in the Tracker with a management response for audit purposes. However, these should not be treated as recommendations that require the Health Board to update or monitor their implementation.

Further detail on how these are monitored is provided in Section 4.

Once the relevant director(s) has approved the management response and action plan, they should be submitted to the Corporate Governance Director's office, where management responses will be reviewed to ensure that they meet the expected response standards before being submitted to the respective audit team to ensure that the risks have been adequately addressed and the timescales are acceptable; once approved by the auditors, the report is issued as final.

The final report will be distributed to the Health Board via the Corporate Governance Director's office to ensure dissemination to the Lead Director(s) and key stakeholders, as well as compliance with the Health Board's internal governance process.

The Executive Team will be provided with all final audit reports at an Executive Committee meeting for their awareness before they are presented

to the ARA Committee, with a particular focus on limited or no assurance rated reviews. The ARA Committee will be required to understand the level of assurance provided, the recommendations for improvement made to management, and the response of management. This will ensure that the ARA Committee is promptly informed of all audit findings and assurances.

The Director of Corporate Governance will maintain a database of all Internal and External Audit Reports, inclusive of management responses/action plans.

A flowchart setting out the process for the management of audit reports when issued is set out at **Appendix A**.

4. MONITORING IMPLEMENTATION OF INTERNAL AND EXTERNAL AUDIT RECOMMENDATIONS

An important responsibility of the ARA Committee is to monitor the implementation of agreed audit recommendations. The ARA Committee should ensure the organisation adopts a robust process for monitoring the implementation of agreed audit recommendations and that regular progress reports are provided to the ARA Committee identifying any that have not been implemented within agreed timescales.

The process for monitoring and reporting progress against the implementation of internal and external audit recommendations within the Health Board will be led by the Director of Corporate Governance.

The key principles associated with the monitoring of internal and external audit recommendations include:

- Audit Recommendations will be added to the Audit Recommendations Tracker, once the final Audit Report has been received by the ARA Committee;
- **Recommendations that fall outside the Health Board's scope to implement will be listed on a separate sheet of the Tracker for audit purposes;**
- Executive Directors will be responsible for respective audit recommendations and ensure oversight of progress within respective teams;
- The ARA Committee will monitor progress against the implementation of all audit recommendations, regardless of priority rating (high, medium, low and not rated), as set out in **Appendix B**;
- Executive Directors, with their teams, will be asked to update on progress against the implementation of audit recommendations as the completion date arises and an update will be reported to the next meeting of the ARA Committee;
- Executive Directors will be responsible for approving the closure of audit recommendations, which will be subject to reporting to the ARA Committee;

- The Committee will be updated on out-of-scope recommendations in the following scenarios
 - **Scenario 1:** If the implementation of local recommendations has stalled due to delays in national progress beyond the expected timeframe, this issue should be highlighted in the Audit Tracking Report to the Committee. The Committee will then decide if escalation to the third-party organisation through the Health Board is necessary.
 - **Scenario 2:** When only one recommendation remains against an audit report, the Head of Corporate Risk and Assurance will cross-check this recommendation against the out-of-scope recommendations log in the Tracker to identify any related recommendations.

A status update will be requested from the Executive Director concerning these out-of-scope recommendations to ensure completeness and accuracy. The updates will be reported to the ARA Committee, providing a clear audit trail and either indicating any barriers to implementation or confirming that all recommendations have been fully addressed.

- The ARA Committee will focus its attention at each meeting on those recommendations that are overdue past the original agreed timeframe for completion, those that have been closed during the last reporting period which require noting and the number of audit recommendations that are not yet due for completion;
- The ARA Committee will be asked to approve the revision of any previously agreed dates within action plans, on the advice of internal or external audit;
- Internal and External Audit Teams will assess the position against previous audit recommendations as part of any relevant follow-up audit work.
- Following the Committee's approval, recommendations that have been completed will be transferred to the completed log, while those still in progress will remain on the Tracker until they are fully resolved.
- Both the Executive Team and the ARA Committee will undertake an in-depth review of the Audit Recommendation Tracker twice-yearly;

Where the ARA Committee or Head of Internal Audit/External Auditor are concerned about the lack of implementation of audit recommendations in a particular area, the ARA Committee has the authority to invite the respective Director to attend and provide an update. This will be with a view to ensuring risks and identified weaknesses in internal control are mitigated, recognising that the initial action plan will have been approved by management.

Where it is possible to do so, as part of the updates to the ARA Committee, and particularly as part of a proposed closure of recommendations, reports will provide an indication of the impact that implementing the recommendation will have had on the Health Board in terms of quality improvement, the provision of more efficient and effective patient care, improved governance, increased security or better use of resources etc.

To ensure transparency and greater oversight of the progress of recommendation implementation and aligned to the oversight of corporate and strategic risks, Board assurance committees will receive an extract of the Audit Tracker relevant to their remit, allowing them to discuss any by exception, e.g., specific recommendations, or to understand where there are issues and provide support to progress implementation.

5. ESCALATION

In most cases, audit reports are issued, finalised, and submitted in sufficient time for Committee meetings. However, there may be instances in which the audit reports for the scheduled ARA Committee meeting are delayed. In such cases, it may be necessary to escalate the issues to the Director of Corporate Governance, Chief Executive, and Chair of the ARA Committee. The subsequent section, "Process for Escalation," outlines the specific situations in which this would arise.

As part of the Annual Audit Plan for both Internal and External Audit, there is a schedule outlining the planned audits. These audits are provisionally scheduled for an ARA Committee meeting. This approach is intended to ensure a balanced distribution of reports received by the ARA Committee throughout the year.

The audits in the annual plans will adhere to the principles of the respective Audit Charter, ensuring that both parties have sufficient time to fulfil their responsibilities. The timeline for the escalation process starts with the initial draft audit report and concludes with the distribution and receipt of the final report, ensuring it is available for the circulation of ARA Committee meeting papers. This includes the Executive Committee reviewing any final audit report(s) for oversight prior to its submission to the ARA Committee.

While both Internal and External Audit must adhere to their respective charters, the Health Board receives a considerably higher number of audit reports from Internal Audit compared to External Audit. The escalation process is established for both bodies, with timeframes determined by the Internal Audit Charter. The same approach would be followed in case of any issues with completing external reports.

The draft outcome report, which includes recommendations and findings, will be received by the Health Board for management responses. The return timeframe is typically 15 working days; however, there may be exceptions. The report will be finalised by the auditing body within ten working days of

receiving the draft response. To ensure that the internal governance process has been adhered to, the Health Board should receive final audits at least seven working days before the ARA Committee meeting.

Process for Escalation

The escalation process only needs to be implemented when the ARA Committee meeting is within 15 working days before the circulation of papers. However, there may be exceptions to the process being initiated, this will be determined in collaboration with the auditors.

An example of the implementation of the escalation process is set out in **Appendix C**.

Stage 1

The auditing body will liaise with the Head of Corporate Risk and Assurance and request assistance when the deadline is approaching, typically around 2 days before. At this stage, the Head of Corporate Risk and Assurance will send a courtesy email to remind and encourage action.

The email will provide details about the governance process and emphasise the importance of meeting the set timeframe to ensure that the reports have been quality assured and returned to the auditing body for timely publication of the final report and availability for the scheduled ARA Committee.

Implementing a prompt email early in the process can be extremely beneficial. It helps identify any disputes with the findings and/or recommendations and allows for early resolution, and ensure it remains on track with the audit plan. Furthermore, it also reduces the risk of needing to escalate the matter to the Director of Corporate Governance, Chief Executive or Chair of the ARA Committee.

Stage 2

If the timeframe has expired and considering the closeness of the timeframe to the audit committee meeting, the Head of Risk and Assurance will bring the matter to the attention of the Director of Corporate Governance, 15 working days prior to the Audit meeting.

The Director of Corporate Governance will follow up on the email sent by the Head of Risk and Assurance, emphasising the need for prompt action from management to complete the reports and outlining the escalation process.

Stage 3

Escalation to the Chief Executive will be implemented if the Director of Corporate Governance's intervention has not resulted in the receipt of the final report or reports seven days before the Executive Committee meeting and ten working days before the ARA Committee meeting. The Chief

Executive will request the Lead Director to prioritise completion within 24 hours.

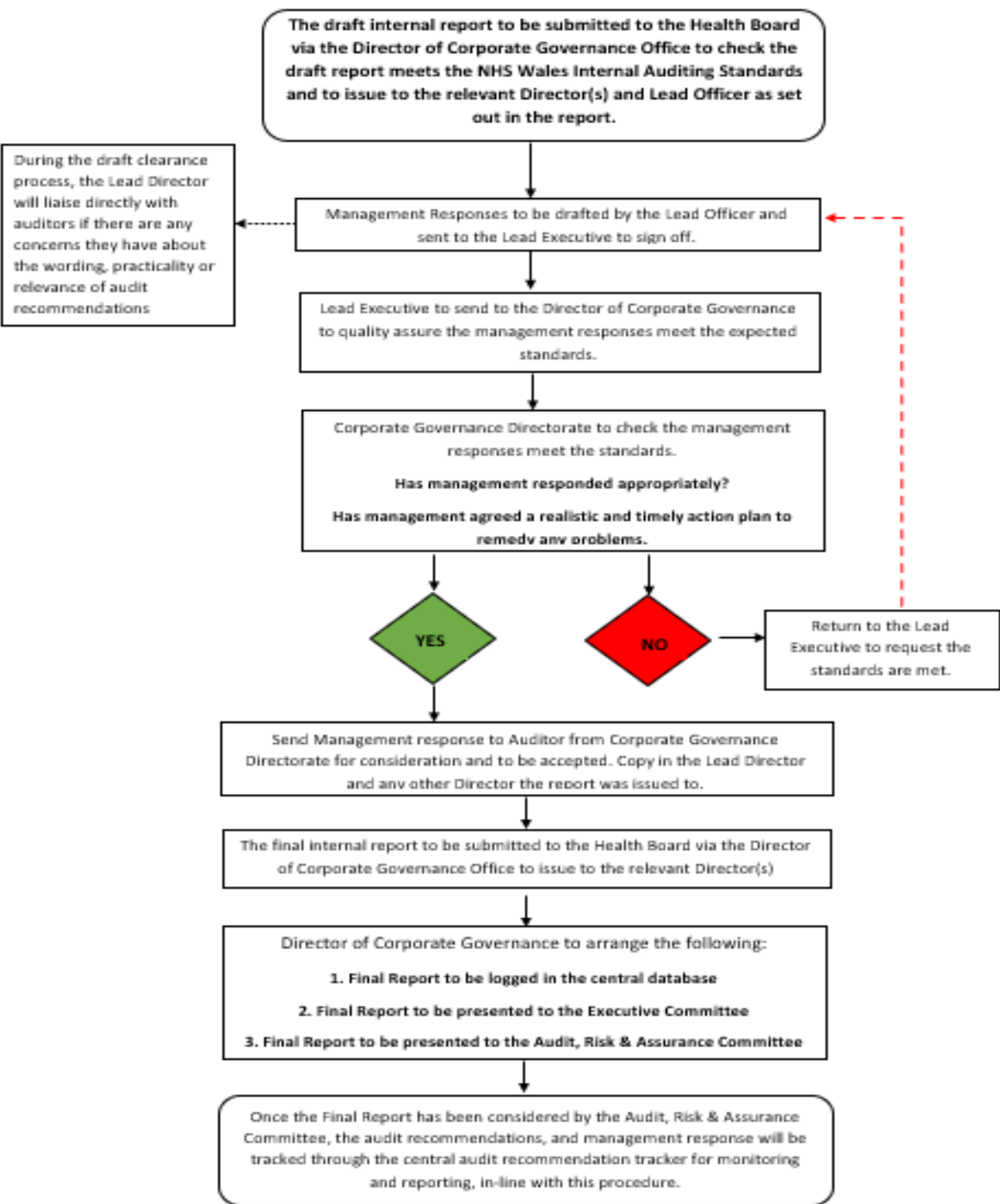
If the auditing body receive the report(s) within 8 working days of the meeting the Head of Corporate Risk and Assurance will need to speak with the auditing body to determine whether the audit can be completed and submitted in preparation for distribution of papers.

Stage 4

If the auditing body is not able to submit the final reports to the Health Board on time for them to be included in the circulation of the ARA Committee papers the Director of Corporate Governance will contact the Chair of ARA Committee to explain the situation.

A decision will then be made regarding whether the reports should be removed from the ARA Committee agenda and postponed to the next ARA Committee and Executive Committee meeting or if they are in the final stage of completion (auditor finalising the report) whether these be marked as to follow and circulated a maximum of 72 hours before the Committee meeting.

Appendix A - Process for Distributing Draft and Final Internal and External Audit Reports



NB: Office of the Director of Corporate Governance refers to the Director of Corporate Governance and the Head of Corporate Risk and Assurance.

Appendix B - Prioritisation of Internal and External Audit Recommendations

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence is present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*
* Unless a more appropriate timescale is identified/agreed at the assignment.		

Appendix C: Example of when the Escalation Process should be Implemented

The purpose of this example is to illustrate when the escalation process would be initiated if a draft report was issued six weeks prior to the ARA Committee meeting, and both parties utilised the full time allowed to complete their responsibilities.

In practice, draft reports are usually issued, finalised, and submitted well in advance of Committee meetings. However, the escalation process should be employed judiciously, depending on the complexity of the audit and the outcome of the assurance work. This approach ensures that the escalation process is only used when necessary, maintaining efficiency while addressing significant issues or delays effectively.

Key Dates	Status of the Audit Report	Date the escalation process should be implemented	Action
Day 1 06 May	Draft Report issued to the Health Board with 15 days turnaround time		
Day 15 24 May	Health Board Management Response submission due to Auditor.	22 May	Implement Stage 1
		The Auditor will continue to follow up with Lead Executive via email to complete.	
		03 June	Implement Stage 2
		The Auditor will continue to follow up with Lead Executive via email to complete.	
		10 June	Implement Stage 3
		The Auditor will continue to follow up with Lead Executive via email to complete.	
		14 June	Implement Stage 4
10 June	Final Report issued to Health Board		
17 June	Final Audit Reports included in circulation of ARA Committee Papers		
20 June	Final Audit Reports must be received by the Executive Committee no later than the Thursday before the scheduled ARA Committee meeting. If the reports are not received by this deadline, they will not be included in the agenda for the upcoming ARA Committee meeting.		
24 June	ARA Committee Meeting		



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	12 September 2024
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Internal and External Audit Recommendation Tracker
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Corporate Risk and Assurance

Pwrpas yr Adroddiad (dewiswch fel yn addas) Purpose of the Report (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA SBAR REPORT
<u>Sefyllfa / Situation</u> This report provides the Audit Risk and Assurance Committee (the Committee) with a comprehensive overview of the current status of all identified internal and external audit recommendations as of 31 August 2024. The report also updates the Committee on the progress made since the last reporting period, highlighting recommendations with revised deadlines, those that remain outstanding, and those where management action plans have been fully implemented.
<u>Cefndir / Background</u> As of the end of the last reporting period on 30 June 2024, the following was noted: • 49 recommendations were completed. • 52 recommendations had their timeframes revised. • 8 internal and external recommendations remained overdue. From 01 July to 31 August 2024: • An additional 49 recommendations became overdue. • 57 updates were requested for overdue recommendations within this period.



Internal and External Audit Recommendation Tracking

The master tracker has been updated to include all Internal and External Audit Recommendations up to the last Committee meeting on 09 July 2024. This tracker includes a total of 142 recommendations across 40 audits, though only those overdue by 31 August 2024 are detailed in this report.

As stated, a total of **57** recommendations required an update on progress. Table 1 provides the Committee with a breakdown of the **57** recommendations by the Lead Director.

Table 1

Overview of Number Updates <u>Requested</u>									
Lead Director	Chief Operating Officer	Director of Corporate Governance	Director of Digital	Director of Finance and Procurement	Director of Nursing	Director of Strategy, Planning & Partnerships	Director of Workforce	Director of Therapies & Health Science	Total
Total recommendations requiring an update	8	7	10	15	6	6	3	2	57

The position reported in Table 2 reflects the position following updates received from Lead Directors against their overdue recommendations. The Committee is asked to approve **30** revised deadlines and **24** completed recommendations.

Table 2

Overview of the Position Following Update <u>Return</u>									
Lead Director	Chief Operating Officer	Director of Corporate Governance	Director of Digital	Director of Finance and Procurement	Director of Nursing	Director of Strategy, Planning & Partnerships	Director of Workforce	Director of Therapies & Health Science	TOTAL
Revised Deadline	5	4	7	7	3	2	2	-	30
Completed	3	3	3	8	2	2	1	2	24
Residual Overdue against Deadline	-	-	-	-	1	2	-	-	3
Reconciliation with requested updates	8	7	10	15	6	6	3	2	57

The information in Table 2 is broken down in Tables 3 – 5 as follows: -

- **Table 3:** Details the 30 revised deadlines. (See Appendix A for revised implementation dates)
- **Table 4:** Lists the 3 residual overdue recommendations. (See Appendix B for details)
- **Table 5:** Highlights the 24 completed recommendations. (See Appendix C for details)

Table 3

REVISED DEADLINES			
Audit Year and Title	Assurance Rating	Number by Priority Rating	
2020: IM&T Control & Risk Assessment - Advisory	Not Rated	4	
2021: IT System Controls (WRIS)	Reasonable	3	
2022: Policies	Limited	1	2
2022: Records Management	Limited	1	
2022: Robotic process Automation	Reasonable	1	
2022: Discharge Planning	Limited	1	
2022: Dementia Services	Reasonable	2	
2023: Facilities	Limited	1	
2023: Estates Condition	Limited	1	1
2023: IT Infrastructure	Reasonable	1	
2023: Decarbonisation	Limited	1	
2023: ABUHB Financial Controls Regional Partnership Board	Limited	3	3
2023: Theatres Stock	Reasonable	1	
2023: Structured Assessment	Not Rated	1	
2023: Review of Workforce Planning Arrangements	Not Rated	2	
TOTAL		30	

Table 4



Audit Year and Title	Assurance Rating	Number of Overdue Recommendations by Priority Rating (No revised deadline)
2022: Discharge Planning	Limited	1
2023: Estates Condition	Limited	2
TOTAL		3

Table 6

COMPLETED RECOMMENDATIONS			
Audit Year and Title	Assurance Rating	Number by Priority Rating	
2017: Medical Equipment and Devices	Limited	2	
2021: Primary Care (External Audit)	Not Rated	1	
2022: Policies	Limited	1	1
2022: Records Management	Limited	1	
2023: Facilities	Limited	2	
2023: Estates Condition	Limited	1	1
2023: Unified Breast Unit at Ysbyty Ystrad Fawr	Substantial	1	
2023: Asset Management	Reasonable	1	
2023: Long Term Sickness Absence Management	Reasonable	1	
2023: IT Infrastructure	Reasonable	1	
2023: Decarbonisation	Limited	3	
2023: ABUHB Financial Controls Regional Partnership Board	Limited	2	2
2023: Intra-Site Patient Transfer	Reasonable	1	
2023: LINC Programme	Reasonable	1	
2023: Primary Care Follow UP (External Audit)	Not Rated	1	
TOTAL		24	



At the last Committee meeting, it was agreed that the report would include more detailed information on any recommendation requesting a revised deadline beyond the agreed threshold of two extensions. In this reporting period, 11 recommendations have exceeded that threshold (**Appendix D**).

For the next reporting period, if any recommendation requests an additional extension beyond the threshold, a Briefing Note will be requested, and the Executive Lead will be asked to attend the Committee meeting to explain the reason for the further extension.

This approach will ensure accountability and transparency in the audit process. By requiring more detailed reporting and justifications for multiple deadline extensions, the Committee can better understand the challenges or obstacles preventing timely implementation of recommendations. It will also help to:

- **Ensure Accountability:** Executive Leads are held accountable for the progress of their recommendations, preventing delays from going unchecked.
- **Improve Oversight:** The Committee gains deeper insights into the reasons behind delays, allowing for more informed decision-making and support where needed.
- **Encourage Timely Action:** By setting clear expectations for explanations and justifications, it motivates the responsible parties to prioritise the completion of recommendations.
- **Enhance Governance:** This process strengthens the overall governance framework by ensuring that audit recommendations, which are often crucial for organisational improvement, are not overlooked or delayed indefinitely.

Argymhelliad / Recommendation

The Audit, Risk & Assurance Committee is asked to:

- **APPROVE** the revised timescales for the **30** Recommendations;
- **NOTE** the status of the **3** overdue audit recommendations;
- **NOTE** the completion of **24** audit recommendations; and,
- **NOTE** the ongoing efforts to ensure timely completion of recommendations.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Risks associated with overdue recommendations will be captured locally and escalated to the strategic risk register if necessary.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item. Choose an item.



Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Integral to the delivery of the IMTP
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:

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

Effaith: (rhaid cwblhau) Impact: (must be completed)

	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA (Equality Impact Assessment) is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well, Being of Future Generations Act – 5 ways of working	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies



<https://futuregenerations.wales/about-us/future-generations-act/>



Health Type	Initial Due Date	Report Title	Recommendation Status	Director	Responsible Officer	Priority	Recommendation ID	Recommendation	Start/In Progress Date	Monthly agreed agreed deadline	Proposed Revised Deadline	Monthly agreed agreed deadline	Date Revised agreed agreed deadline	Final Report Due Date	Report Due Date	Number of revised recommendations requested including new request	If closed and not complete please provide justification and ensure evidence is available	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close/complete the recommendation?
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital	N/A	R1	R1 The governance framework for IM&T / digital should be clarified and where control over aspects of IM&T has devolved to departments, there should be a process for these to feed into the relevant Committee to ensure oversight. Underneath the Committee the steering group remit and membership should be defined.	30/06/2021	-17.97	31/08/2024	0.00	Overdue	Overdue	5		August 2024: Agreed that the clinical council will report into the wider Health Board's clinical advisory group so terms of reference now being reviewed to note this change.				
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital / Assistant Director for Strategy, Planning & Design	N/A	R5	R5 The Health Board should ensure greater links with divisions and the informatics Directorate. The informatics Directorate should be involved in the decision making process for all IM&T items.	31/03/2021	-40.95	30/09/2024	0.98	Overdue	Overdue	4		August 2024: agreed format for Divisional Meetings with Mental Health, Families & Therapies and Medicine. Anticipate meetings will be in place by end of Q3				
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital / Assistant Director for Strategy, Planning & Design	N/A	R9	R9 A network of champions across the organisation should be established. The Digital Strategy should be reviewed alongside the roadmap. This should form the basis for engaging the network of champions to drive the strategy forward.	30/09/2021	-14.95	31/10/2024	2.00	Overdue	Overdue	4		"August 2024: Digital Champions in place through the MS65 Team. Business partnering to be reviewed by O&T Senior Leadership Team"				
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital	N/A	R13	R13 Critical assets should be identified within the asset and configuration management systems.	31/12/2021	-31.93	31/07/2025	10.95	Overdue	Overdue	4		August 2024: A review of the cyber security plan and Information Asset Register has identified significant work remains to understand critical assets across the estate alongside the new security platform mentioned in the				
Internal	2021.12	IT System Controls (WMS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R7	R7 The success of the use of the lawers list should be monitored to ensure that it works as anticipated and that all lower accounts are removed on a timely basis.	30/04/2022	-28.00	01/12/2025	14.98	Overdue	Overdue	3		Aug 2024: We are still limited to users outside of Radiology but there is communication for those internal to Radiology though it's not automated and dependant on people informing us of this. Outside of Radiology IT should disable their account in AD which will disable their access to the Healthboards systems. The new RIS/PACS access is dependant on being added to the appropriate AD groups which will be disabled when they leave the Healthboard.	Time and resource in Radis. As well as pending RSP program may not help development.			
Internal	2021.12	IT System Controls (WMS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R8	R8 The Health Board should request that this logging function be developed and should consider feeding WMS events into the SBAR.	31/03/2022	-28.98	01/12/2025	14.98	Overdue	Overdue	3		Aug 2024: There is no adequate audit functionality within Radis and with the product being soon end of life there will be no solution until the new PAC/RIS is in place which has thorough audit functionality.				
Internal	2021.12	IT System Controls (WMS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R9	R9 A formal disaster recovery plan for WMS should be developed.	30/04/2022	-28.00	01/12/2025	14.98	Overdue	Overdue	3		Aug 2024: We don't have a mirrored DR system in place for PACS or RIS. We would still be dependant on setting up mini-PACS at each site which is time consuming and not a true DR system. The new PAC/RIS will be predominantly cloud based with short term storage and full functionality of our PACS in RIS in our DC in G4H and a smaller backup in our VAE DC. With the fibre connection between both DC the VAEH should stretch and we could have a true DR system for continuity.	Aug 2023: Time and resource in Radis. As well as pending RSP program may not help development.			
Internal	2022.11	Policies	Linked	Director of Corporate Governance	Head of Corporate Governance	Low	R3	R3 The Health Board should consider the relevant Health and Care Standards when reviewing / updating a policy or other relevant documentation. An acknowledgement of this process should be included, together with the titles of the relevant Standards included.	29/09/2023	-11.00	31/10/2024	2.00	Overdue	Overdue	4		August 2024: Policy Management Framework to be presented to Board September 2024 (finalised and scheduled). This was deferred from July 2024 due to engagement with staff groups on the content.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			
Internal	2022.11	Policies	Linked	Director of Corporate Governance	Head of Corporate Governance	Medium	R4	R4 The Health Board, alongside recommendation 3.1 should consider automating the submission of a policy from the responsible owner, to ensure that a consistent submission format is achieved.	29/09/2023	-11.00	31/10/2024	2.00	Overdue	Overdue	4		August 2024: Partially complete. SharePoint system in place and automated flagging and reminder system established / Review of templates and submission process included within the revised Policy Management framework scheduled for submission to Board in September 2024.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			
Internal	2022.11	Policies	Linked	Director of Corporate Governance	Head of Corporate Governance	Medium	R1	R1 The Health Board should review the types of policy documents retained and hosted, to determine if each of them should adhere to the Policy, for example, departmental standard operating procedures to be managed entirely within the respective division. Alongside this review, the document owner should be determined to ensure the responsibility remains with the most appropriate individual.	31/03/2023	-17.00	31/10/2024	2.00	Overdue	Overdue	4		June 2024: Clarification of definitions of WCDs and Health Board v/s local documents included within the revised policy framework, to be presented to Board in July 2024.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues			
Internal	2022.12	Records Management	Linked	Director of Digital	DPO & Head of IG	Medium	R5	R5 The need for records management storage places should be regularly reviewed to ensure that sufficient spaces are available for record keeping purposes.	31/12/2023	-8.00	31/03/2025	6.95	Overdue	Overdue	2		August 24: Continuing issue with mould and water ingress, danger of holes in glass roof within storage area in St Gabrels requires immediate attention as will not be permitted to remove or track records from this area following visit by health and safety. Urgent remediation work required and involves into the digitisation of mental health records as they require long term storage and no suitable premises have been identified.				
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Assistant Director for Strategy, Planning & Design	Low	R1	A formal SOP should be defined that sets out how the RPA process is to be managed. The operational service model should be fully defined and the terms of reference for the governance board reviewed and updated.	01/06/2023	-14.98	31/12/2024	4.00	Overdue	Overdue	4		August 2024: Work on the delivery model has been delayed due to a focus on transitioning all existing automations onto a new BPC platform as part of essential maintenance work to secure a sustainable service. It is expected that the operational delivery model will be completed by the end of the calendar year.				
Internal	2022.19	Discharge Planning	Linked	Director of Nursing	Assistant Medical Director for Planning	High	R3	In respect of day care episodes of care, there are many diagnostic / treatment areas and specialities who have different methods of notifying both the GP and patient of the care episode. We acknowledge that this is not a standard approach with some departments continuing the clinical details at the discharge summary. As part of the Task and Finish group, the Assistant Medical Director for planning will ensure that discharge notifications form part of the standardised approach. For inter-site transfers an SBAR is completed for every patient that outlines the patient's condition, diagnosis and any actions needed to be taken by the receiving site.	01/04/2024	-4.98	31/10/2024	0.00	Overdue	Overdue	2		June: SBAR documentation is embedded and used as standard in all inter site transfers. SBAR has review periods to make sure it is current and user friendly to ensure the correct information is on the document. The SBAR was reviewed May 2024 and new version will be rolled out August 2024				
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Lead Nurse for DMMH / Informatics Programme Manager - WCCS	Low	R3	Training should be provided to ensure a consistent approach for the electronic and paper records completion	01/07/2023	-14.00	31/03/2025	6.95	Overdue	Overdue	2		July 2024: Memory Assessment Workstream 2a meets Monthly and is chaired by the Directorate Manager for DMMH services. A performance manager for the DMMH is now leading on the performance targets set out for the Diagnosis and assessment of Dementia.	Nov 2023: This action needs to be part of the wider patient flow and discharge in ABUHB. Invites to the Dementia workshop 4 meetings will help us understand the challenges and solution and future measurements.	Nov 2023: Recorded and reviewing the membership of work stream 4 and action plan from the National Audit of Dementia.		
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Programme Manager looking at with Patient Flow Leads	Low	R4	Where operationally and clinically possible, a patient's locality should be considered as part of the admission / transfer process.	01/09/2023	-11.97	31/03/2025	6.95	Overdue	Overdue	1		July 2024: Patient Flow team are invited to the Hospital Charter Steering Group. Lead Nurse Dementia is now on the Redesign for Older Person frailty group & Discharge planning group. These opportunities will facilitate discussion and planning for appropriate placement and hospital moves.	Nov 2023: Pulse Welsh Language and engagement pages on the intranet as well as a Welsh Language team who we collaborate with closely			
Internal	2023.05	Facilities	Linked	Chief Operating Officer	Business Support Manager	Medium	R7.4	Management should investigate the following system improvements and implement if appropriate: Bank: • the possibility of using the Allocated function within the Bank Staff system to create a better approach to allocating bank shifts to a wider pool of staff; • utilisation of safe care to monitor when staff start and end their shifts; and • the completion of the programme of work to prevent staff from completing all associated steps of approving and paying a bank shift.	29/02/2024	-6.03	01/07/2025	9.97	Overdue	Overdue	1		August 2024: Of these three actions recommended, we have only addressed the one concerning the use of safe care. Central rostering has informed us that this element of the tool is currently prioritised for nursing staff, and its rollout to nursing patches is the primary focus, which means we are unable to utilise it at this time. Consequently, we will continue to monitor the situation with the rostering rollout, but for now, it is not feasible for our division to implement this action. However, the other two actions are manageable and require no further comment. This has been reported and is not feasible. Will be considered with wider HR and rationality to see if becomes viable in the future as part of wider Roster roll out				
Internal	2023.06	Estates Condition	Linked	Director of Strategy, Planning & Partnerships	Director of Strategy, Planning & Partnerships	Medium	R4.2	Management should update the Estates Strategy (or equivalent) for continued relevance to estates condition as appropriate.	31/03/2024	-5.02	31/03/2025	6.95	Overdue	Overdue	2		Aug 2024: As per the June update, the Organisational Strategy is expected to be completed by the end of the calendar year. The PPMHC is considering estates development in detail and requires regular updates on the strategy's progress. Update on plans for all awarded estates presented to PPMHC. Board Development session on Estates. Estates Strategy to follow Organisational Strategy.				
Internal	2023.06	Estates Condition	Linked	Director of Strategy, Planning & Partnerships	Devised Director of Estates and Facilities	High	R5	The adequacy of the existing Capital Development & Estates workforce will be affirmed (in terms of capacity and associated skill sets required) and to inform a financial model for required recruitment/sup.	31/06/2024	-3.02	31/10/2024	2.00	Overdue	Overdue	2		Aug 2024: Work remains ongoing to assess all the necessary detail and any proposals for consideration. At this stage the operation challenge focuses on recruiting to the existing vacancies.				
Internal	2023.17	IT Infrastructure	Reasonable	Director of Digital	Chief Technology Officer	Medium	R.2	A set of formal procedure documentation and guides for managing the infrastructure should be defined.	31/07/2024	-1.02	30/06/2024	0.98	Overdue	Overdue	1		July 2024: The Resources area of the O&T SharePoint site contains approved and published policies and procedures that span the directorate. All of the document requirements for Service Desk Institute Audit are here plus many others. A review with Head of ICT and team managers will be undertaken to identify and fill any gaps.				
Internal	2023.25	Decarbonisation	Linked	Director of Finance and Procurement	Director of Finance/Decarbonisation and SD	Medium	2.1	The specific risk that the Health Board is unlikely to reach the Welsh Government targets of 18% emissions reduction by 2025 and 34% reduction by 2030 needs to be clearly raised.	30/09/2024		30/06/2024	0.98	Overdue	Overdue	1		Agreed - this is already under consideration and a full analysis is in construction for the Board.	01/24: Risk R795 closed as duplicate. Risk 7992 reviewed and updated and governance reviewed. Monthly directorate risk meetings in place to manage ongoing monitoring of risk. Joint risk review between directorate and O&T established via formal monthly meetings.	Action Log to be updated regularly		
Internal	2023.28	ABUHB Financial Controls Regional Partnership Board	Linked	Director of Finance and Procurement	Deputy Director of Strategy, Planning & Partnerships and Assistant Finance Director for Out of Hospital & Partnership	Medium	1.2	We recommend that the Health Board develop a roles and responsibilities document (internal and external), detailing the process for negotiating funds and the information required including meeting minutes. This approach could be replicated to cover all outputs provided by the Health Board to the RPB and consideration should be given to including the deliverables provided by the Regional Partnership Team hosted by Torfaen County Borough Council, as they also impact activities.	31/07/2024		30/11/2024	2.98	Overdue	Overdue	1		The ABUHB PMO/Finance teams have reviewed their processes to ensure the recommendations have been addressed. Where possible, to ensure there is appropriate segregation of duties, the PMO will be processing requisition requests, with the finance team requisitioning orders when the appropriate governance has been obtained. The information required has also been reviewed with formal award letters which detail the terms and conditions of the grant award to be the main source of award award controls to enable requisitioning. In cases where award letters are not appropriate, then RPB/CID approved reports with minimal decision logs would also suffice. To complete this action, the Draft Memorandum of Understanding which is currently awaiting review by Corporate Governance will need to be approved by ABUHB, and subsequently the R.P.B.				
Internal	2023.28	ABUHB Financial Controls Regional Partnership Board	Linked	Director of Finance and Procurement	Deputy Director of Strategy, Planning & Partnerships and Assistant Finance Director for Out of Hospital & Partnerships	High	2.1.2	We recommend that the Health Board ensures that clarity is provided by defining the purchase requisition and purchase order process for RPB funding payments, made by the Health Board on behalf of the RPB, indicating the level of detail required to be noted on purchase requisitions and purchase orders. This should include specific reference on the documents that payments may, or may not, be made in advance to third sector organisations, and may, or may not, include accruals claimed by the funding recipient where permitted by any funding award letter.	31/07/2024		30/11/2024	2.98	Overdue	Overdue	1		2.1.2 Payments to Third Sector Organisations The MoU referenced above has been set out to address this matter where by Third sector Organisations can only claim funding monthly in arrears going forward. This information has also been reflected within the grant terms and conditions for 2024/25 and therefore not required for inclusion in the requisition detail	"As an interim solution, the roles and responsibilities with the ABUHB PMO and finance teams have been reviewed and clarified, ensuring there is clarity in the process for raising purchase requisitions, purchase order and requisitioning funds. This also included the information required.			
Internal	2023.28	ABUHB Financial Controls Regional Partnership Board	Linked	Director of Finance and Procurement	Assistant Finance Director for Out of Hospital & Partnership	High	2.1.3	We recommend that the Health Board ensures that clarity is provided by defining the purchase requisition and purchase order process for RPB funding payments, made by the Health Board on behalf of the RPB, indicating the level of detail required to be noted on purchase requisitions and purchase orders. This should include specific reference on the documents that payments may, or may not, be made in advance to third sector organisations, and may, or may not, include accruals claimed by the funding recipient where permitted by any funding award letter.	30/08/2024		30/11/2024	2.98	Overdue	Overdue	1		2.1.3 However, communication to the organisations impacted by this change will need to be managed in line with the issuing of the grant award letter. There are exceptional instances whereby a payment will need to be paid in advance, for example, the funding for small grant schemes. This will be managed as noted in section 2.2.	In addition, following the guidance included in 10.6.2 of the Health Board's SPS, an SBAR was approved by the Exec w/c 5/08/24, allowing third sector organisations to continue with the historical arrangement whereby claims are made quarterly in advance, with the exception of small grant schemes, which are fully paid in advance following approval from the RPB. This arrangement has been agreed for 24/25 and will be revisited annually to ensure that the appropriate governance is in place to facilitate these type of payments which have been approved by the RPB. To complete this action, the Draft Memorandum of Understanding which is currently awaiting review by Corporate Governance will need to be approved by ABUHB, and subsequently the R.P.B.	As an interim solution, an SBAR was approved by the Exec w/c 5/08/24 following the guidance included in 10.6.2 of the Health Board's SPS. The interim payments terms are reflected in the grant terms & conditions issued to the receiving organisation. To complete this action, the Draft Memorandum of Understanding which is currently awaiting review by Corporate Governance will need to be approved by ABUHB, and subsequently the R.P.B. The SPS can then be updated.		
Internal	2023.28	ABUHB Financial Controls Regional Partnership Board	Linked	Director of Finance and Procurement	Assistant Finance Director for Out of Hospital & Partnerships	High	2.2	We recommend that the Health Board ensures that consideration is given to amending the Accounts Payable FCP, to include reference to any legitimate purchase order process covering RPB funding processes. This should include possible payments in advance, referring to the requirements of the SPS, Section 10.6, Prepayments, and the inclusion of funding to third parties on the basis of accrued costs.	30/04/2024		31/12/2024	4.00	Overdue	Overdue	1		This will be reviewed and updated as required following the conclusion of sections 2.1, 2.3, 5.1 and 5.2.	The grant terms and conditions have been amended to reflect payments made on the basis of costs incurred by the receiving organisation and not considered appropriate to amend the FCP in this scenario. To complete this action, the Draft Memorandum of Understanding which is currently awaiting review by Corporate Governance will need to be approved by ABUHB, and subsequently the R.P.B.			
Internal	2023.28	ABUHB Financial Controls Regional Partnership Board	Linked	Director of Finance and Procurement	Assistant Finance Director for Out of Hospital & Partnerships	Medium	2.3.3	We recommend that the Health Board ensures that clarity is provided over the steps to be taken with any internal financial checks and the evidence retention required, to ensure Section 6.1 of the Accounts Payable Financial Control Procedure is adhered to.	31/07/2024		30/06/2024	0.98	Overdue	Overdue	1		2.3.3 A list of appropriate documentation, such as award letters, approved reports, minutes and decision logs, will also be included in the standard operating procedure to ensure orders are raised with the correct evidence and approvals.	This is currently nearing completion. Purchase requisitions are raised after the indicative award letters are provided. The payment tracker has been enhanced to capture all details of each requisition, including the approvals. Additionally, the tracker contains a decision log regarding assurance for claims. Once this process is operating as expected the standard operating procedures will be updated accordingly.	Internal processes have been reviewed and now reflect the approved documentation list, however, the memorandum of understanding will need to be finalised to ensure that the partnerships are aware of the expected documentation required to support this process. In the interim, this information has been included in the award terms and conditions.		
Internal	2023.28	ABUHB Financial Controls Regional Partnership Board	Linked	Director of Finance and Procurement	Assistant Finance Director for Out of Hospital & Partnerships	Medium	5.1	We recommend that the Health Board provides clarity to all parties, to ensure purchase invoices are sent to the central Accounts Payable address. If this is not considered appropriate, then the purchase order detail should be amended, and any such deviation from the Accounts Payable FCP be documented and approved.	31/07/2024		30/06/2024	0.98	Overdue	Overdue	1		Having considered the recommendation and the complexities of the partnership arrangement, it has been agreed that it is not appropriate for invoices to be sent directly to the central Accounts Payable address. This will increase the risk of payments being made in error. Arrangements will be made for the purchase order details to be amended, and the deviation from the Accounts Payable FCP to be documented and approved.	Aug 2024: Having looked into the options, changing the address on the purchase order may create further risk and confusion for non-RPB related orders. Therefore, it has been agreed that the request for invoices to be addressed to the PMO finance address will be included in the body of the requisition as an appropriate alternative. Section 6.1.3 Address on PO of the Accounts Payable FCP has been reviewed and will be updated to reflect this as an exception. This will need to be presented to the ABUHB Executive Committee for review, followed by the Audit Risk & Assurance Committee on the 12th November 24.			
Internal	2023.31	Theatre Stocks	Reasonable	Chief Operating Officer	Business Support and Operational System Manager/Service Manager PACCT	High	3.1	We recommend that workflows are redesigned to enable the stripping out of legitimate discrepancies from reported O&H differences (Discrepancies) and that the remainder are <u>intentionally investigated</u> further to determine their cause.	30/09/2024		01/06/2024	0.03	Overdue	Overdue	1		Investigation of discrepancies is time consuming and complex. We detail the null transactions made by staff via reporting, this is shared with the Senior Theatre Team to improve clinical team practices. There are limitations in further development due to the time required to investigate this to the level of detail required, particularly against competing demands and expanding workload. However, we are currently reviewing the level of stock control resource and assessing the risk further. Following the review we will be in the position to reassess and if required prioritise workstream/resource demand. The target date of September 30, 2024, remains unchanged.	August 2024: The investigation into discrepancies is ongoing, and the findings or report will be shared with the staff and the Senior Theatre Team to enhance clinical team practices. Despite the challenges posed by the detailed level of investigation required and the competing demands on time amidst an expanding workload, we are assessing the risk further and reviewing the level of stock control resource. Post review, we will be in a better position to reassess and, if necessary, prioritise workstream or resource demand. The target date of September 30, 2024, remains unchanged.	01/24: Risk R795 closed as duplicate. Risk 7992 reviewed and updated and governance reviewed. Monthly directorate risk meetings in place to manage ongoing monitoring of risk. Joint risk review between directorate and O&T established via formal monthly meetings.		
External	2023.04 A	Structured Assessment 2023	Not Rated	Director of Corporate Governance	Director of Corporate Governance	High	R2	The Health Board should develop training for Health Board staff around the reporting expectations and quality of information presented to the Board and its committees.	30/06/2024		31/12/2024		Overdue	Overdue	1		The Health Board will be working to review and update its corporate report templates, alongside developing clear guidance and support for the preparation of Board and Committee reports. Securing additional training will also be explored.				
External	2023.05 A	Review of Workforce Planning Arrangements	Not Rated	Director of Workforce & OD	Director of Workforce & OD	High	R3	Medium to long term service workforce modelling is out of date and it is needed to inform sustainable clinical service models. The Health Board should review their central workforce planning capacity and capability to ensure it is sufficient to support their longer term strategic and operational workforce planning requirements.	30/07/2024		31/01/2025		Overdue	Overdue	1		We continue to provide longer term planning alongside National Workforce Strategies being developed by H&W. We will undertake a review of capability and capacity following an assessment of workforce planning requirements via the 2024 MTP.	August 2024: The Health Board is currently engaging the local population in the development of its 10 year strategy "A conversation for a healthy future". This has been based on key design principles. Population engagement will continue until the end of August 2024 with the strategic themes defined by the end of November 2024. A final draft strategy is expected January 2025. Workforce Planning will be offering a local workforce training prospectus over end of August 2024.			
External	2023.05 A	Review of Workforce Planning Arrangements	Not Rated	Director of Workforce & OD	Director of Workforce & OD	High	R6	The People Plan deliverables are subject to scrutiny through People and Culture Committee with updates provided to the Board. The People Plan deliverable benefits and outcomes are also supported by a monthly reported Workforce dashboard. We will look at different ways of time series measures over time to demonstrate outcomes and benefits where appropriate.	31/04/2024		30/06/2024		Overdue	Overdue	1		The People Plan deliverables are subject to scrutiny through People and Culture Committee with updates provided to the Board. The People Plan deliverable benefits and outcomes are also supported by a monthly reported Workforce dashboard. We will look at different ways of time series measures over time to demonstrate outcomes and benefits where appropriate.	August 2024: A revised dashboard has been developed which includes different measurements that demonstrate progress against targets/objectives and impact on delivery. Formal ratification is in progress with a view to launching in August 2024.			

Audit Type	Advisory Ref No.	Report Title	Assurance Status	Director	Responsible Officer	Priority	Recommendation No.	Recommendation	Management Response	Start Date Agreed in Final Report	Monthly progress Agreed Deadline	Proposed Revised Deadline	Monthly progress Revised Deadline	Date Revised Deadline was agreed to other Committee	Final Report Deadline Status	Report Deadline Status	Number of revised Timescales Requested including: new request	If closed and not complete please provide justification and ensure evidence is available	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close/complete the recommendation?
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Medical Director/Assistant Medical Director for Planning/ Director of Nursing	High	R3	All patient discharges from the care of the Health Board are effectively controlled and evidenced by issuing a timely, completed discharge notification.	The Medical Director is aware that the timeliness of some discharge notifications needs to be improved. A letter was sent to all medical staff outlining their responsibilities in respect of timely discharge notifications in 2021. This is now being followed up by the Assistant Medical Director for Planning who will be leading a risk & finish group to develop standardisation of approach. This work will aim to ensure that patients are able to leave hospital with their discharge summary / notification and ensure it will be sent electronically to the GP on the same day.	01/04/2024	-4.98		-1492.95		Overdue		0					
Internal	2023.06	Estates Condition	Limited	Director of Strategy, Planning & Partnerships	Divisional Director of Estates and Facilities	High	R2.1	Appropriate surveys should be undertaken following dialogue with NWSSP/ SES.	Agreed – the Divisional Director has, since the fieldwork for this audit, been involve in two national level conversations with NWSSP about the future of facet surveys and how they should be done. There is no formal funding for regular surveys and these discussions are ongoing relating to most effective and cost effective solutions with WPS and NWSSP across NHS Wales and will dictate the final implementation of this action.	31/08/2024	0.00		-1492.95		Overdue		0		Discussions remain ongoing with SSP on this matter and HIs are not commissioning additional surveys pending these discussions.	Subject to All Wales approach.		
Internal	2023.06	Estates Condition	Limited	Director of Strategy, Planning & Partnerships	Director of Corporate Governance	High	R6	The effectiveness of escalation and oversight of capital and estates related risks should be reviewed, notably as to the Board and relevant committees.	At its meeting in January 2024, the Board approved its Revised Risk Management Framework which set out the revised hierarchy for risk management within the organisation, alongside an agreed risk Appetite Statement. In line with this Framework, the Head of Risk and Assurance will work with the Divisional Director of Estates & Facilities to review the risk management arrangements in place, ensuring appropriate escalation reporting from service to Board level.	31/01/2024	-6.98		-1492.95		Overdue	Overdue	1		June 2024 - The Head of Risk Assurance has scheduled a discussion with the Divisional Director of Facilities to look at how estate risks are monitored and escalated to determine if any estate risks require escalation. There is a commitment to bringing all risks into one report. March 2024 - The Head of Corporate Risk and Assurance will work with Estates to ensure that their divisional risk register is robust and up to date, underpinned by operational risk reporting, and that it feeds the hierarchy process to CRB and SBR (in accordance with the Framework). Furthermore, the Finance & Performance Committee is responsible for seeking assurance on estates compliance matters, which has been included in the committee workplan 2024/25 to ensure sufficient assurance is built in.			

Reported by	Reviewed by	Reviewed Date	Reviewed Status	Reviewed By	Reviewed Date	Reviewed Status	Reviewed By	Reviewed Date	Reviewed Status	Reviewed By	Reviewed Date	Reviewed Status	Reviewed By	Reviewed Date	Reviewed Status	Reviewed By	Reviewed Date	Reviewed Status	Reviewed By	Reviewed Date	Reviewed Status	Reviewed By	Reviewed Date	Reviewed Status
Internal	2017-08	Medical Equipment and Devices (MEDD)	Unaudited	Director of Therapies and Health Sciences	N/A	High	R1	R1 Registers should be maintained for operational management of medical devices and equipment each ward and department, which should record relevant equipment details. The register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed. Each embedded assessor has reviewed all registers, identifying areas for improvement. The register format should be updated / amended on the register, so all items are correctly recorded. Going forward, reduction of equipment, disposals, additions etc., should be updated promptly to ensure an accurate record continues.	The Health Board to consider investing in an overarching equipment database register with staff resources to ensure regular updating and management.	31/03/2018	-76.89	01/06/2024	-0.85	Not Approved	Completed / Closed	Completed / Closed	5	The register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed. The database, structure and format of the register allow controlled oversight of operational equipment deployed in the EBMU services. There is a system in operation for reviewing the accuracy of data. Each area should ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record it upon the register. The database MEDDD update has now taken place. The EBMU team are clear on how the updated version operates and have written user instructions accordingly. The user instruction is being relayed to wards and departments with an offer of user support until such time as users are conversant with the MEDDD software platform. The benefit of utilising this system at ward/departement level is that stock/inventory lists of electrical devices can be downloaded from the central stock database for auditing purposes on a regular basis. The non-electrical medical device audits have been implemented across the healthboard to identify non-compliance with the MEDDD system. The roll-out of user instructions was completed by August 15th. The actions required to provide assurance on this recommendation, R1, can now be considered closed. Discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded. There is a programme of periodic register scrutiny reviews and of auditing the review processes. A mechanism is in place for ward and departmental managers to audit the equipment deployed in their work areas against the register and to report discrepancies for corrective action. Going forward, relocation of equipment, disposals, additions etc., should be updated promptly to ensure an accurate record continues. The Medical database captures equipment lifecycle stage works and changes to the departments to which particular equipment is allocated. Deployment location updates rely on manual reporting by ward and departmental managers or by routine data verification by EBMU or Finance's routine Asset Management activities. A clear robust control mechanism should be established by the divisions / directorates demonstrating the consolidation and delivery of applicable training aligned to medical equipment and devices. Measures have been developed with ward training requirements by general manager group. Ward and departmental managers can cross-reference the models of equipment in use in their respective areas with members of staff that are required to use them. They can use this information to plan the appropriate training courses through CSR. Training records should also be uploaded into ESR. The fourth category of the high-risk conformity managed periodic training courses and training records in relation to infusion devices is now being managed in ESR. Safety is underpinned by the fact that staff are aware by their scope of professional practice and the validity of their professional qualifications by their respective professional and line managers to ensure they are appropriately trained to deliver the tasks they are directed to do. This includes appropriate alignment of bank staff - more comprehensive functionality in ESR will enhance this assurance processes further. The post mandatory training compliance rates with regard to infusion devices / pumps should be addressed as a matter of urgency. Significant work and effort have been carried out since the infusion device training manager came into post 10 months ago, but still, progress against raising compliance remains very difficult to achieve. There was also a large post-Covid increase in the number of trained staff. The measures that have subsequently been put in place since the recruitment have proven extremely effective and resulted in a significant compliance increase from 55% in 2017 to 85% in July 2024 (representative sample size is 75%).						
Internal	2017-08	Medical Equipment and Devices (MEDD)	Unaudited	Director of Therapies and Health Sciences	N/A	High	R2	R2 A clear robust control mechanism should be established by the divisions / directorates demonstrating the consolidation and delivery of applicable training aligned to medical equipment and devices. Training records should also be uploaded into ESR. The post mandatory training compliance rates with regard to infusion devices / pumps should be addressed as a matter of urgency.	From a Divisional perspective, the cascade training provided at ward level has not raised any particular safety issues, although with the increasing use of bank and agency staff, consideration should be given to assistance on-site training for those members of staff. The Health Board to consider establishing a catalogue of equipment that needs specific training to operate, alongside a database of staff competence.	31/03/2018	-76.89	31/06/2024	0.00	Not Approved	Completed / Closed	Completed / Closed	4	Discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded. There is a programme of periodic register scrutiny reviews and of auditing the review processes. A mechanism is in place for ward and departmental managers to audit the equipment deployed in their work areas against the register and to report discrepancies for corrective action. Going forward, relocation of equipment, disposals, additions etc., should be updated promptly to ensure an accurate record continues. The Medical database captures equipment lifecycle stage works and changes to the departments to which particular equipment is allocated. Deployment location updates rely on manual reporting by ward and departmental managers or by routine data verification by EBMU or Finance's routine Asset Management activities. A clear robust control mechanism should be established by the divisions / directorates demonstrating the consolidation and delivery of applicable training aligned to medical equipment and devices. Measures have been developed with ward training requirements by general manager group. Ward and departmental managers can cross-reference the models of equipment in use in their respective areas with members of staff that are required to use them. They can use this information to plan the appropriate training courses through CSR. Training records should also be uploaded into ESR. The fourth category of the high-risk conformity managed periodic training courses and training records in relation to infusion devices is now being managed in ESR. Safety is underpinned by the fact that staff are aware by their scope of professional practice and the validity of their professional qualifications by their respective professional and line managers to ensure they are appropriately trained to deliver the tasks they are directed to do. This includes appropriate alignment of bank staff - more comprehensive functionality in ESR will enhance this assurance processes further. The post mandatory training compliance rates with regard to infusion devices / pumps should be addressed as a matter of urgency. Significant work and effort have been carried out since the infusion device training manager came into post 10 months ago, but still, progress against raising compliance remains very difficult to achieve. There was also a large post-Covid increase in the number of trained staff. The measures that have subsequently been put in place since the recruitment have proven extremely effective and resulted in a significant compliance increase from 55% in 2017 to 85% in July 2024 (representative sample size is 75%).						
Internal	2022-11	Policies	Unaudited	Head of Corporate Governance	Low	High	R2	R2 The Health Board should embed documents / files / forms etc. within a policy document hosted on the intranet. If a form is applicable, it should form part of the appendices or be referenced separately.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WPCDs), the Quality Assurance process will be strengthened and implemented.	20/09/2023	-11.05	-1462.95	3	June 2024 work continues as previously described. Revised Policy Management Framework to be presented to the Board for approval in July 2024 March 2024: This is being advised for newly approved policies and work will be undertaken to address this retrospectively as part of the review of the policy database. Work is underway to review the overarching policy framework and supporting guidance, this will include the requirements around embedded documents. November 2023: This is being advised for newly approved policies and work will be undertaken to address this retrospectively as part of the review of the policy database. Work is underway to review the overarching policy framework and supporting guidance, this will include the requirements around embedded documents.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re-structure. Paths now in place and work continues.	November 2023: Any new policies to be checked for embedded documents prior to publication	This is being advised for newly approved policies and work will be undertaken to address this retrospectively as part of the review of the policy database.							
Internal	2022-11	Policies	Unaudited	Head of Corporate Governance	High	High	R5	R5 To the Health Board should consider fully automating the reminder / management process of all relevant policies / documentation hosted on the intranet. This could be achieved through the use of Power Automate, Logic Apps, or other tools. An automated email workflow would establish a periodic (e.g. weekly) check of all policies listed on the control spreadsheet that are overdue for review and issue automatic emails to the document owners. Following this escalation to the respective Executive Director can also be completed automatically if documentation is still not updated in a timely manner. This would also allow for real-time reporting of documents that are overdue for review, to provide assurance to the respective Committees.	An integrated electronic policy management system will be explored, learning from other health bodies, with an implementation plan developed to support the most appropriate system.	20/09/2023	-11.05	-1462.95	3	June 2024: Partially complete. Automated emails sent to policy manager advising of those policies due for review within 6-monthly/3 months and overdue in order to initiate reminders. Reporting to Committee to be established as part of the review of the policy framework and implementation of a scheme of delegation for policy approval. March 2024: Partially complete. Automated emails sent to policy manager advising of those policies due for review within 6-monthly/3 months and overdue in order to initiate reminders. Reporting to Committee to be established as part of the review of the policy framework and implementation of a scheme of delegation for policy approval. November 2023: Partially complete. Automated emails sent to policy manager advising of those policies due for review within 6-monthly/3 months and overdue in order to initiate reminders. Reporting to Committee to be established as part of the review of the policy framework and implementation of a scheme of delegation for policy approval.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re-structure. Paths now in place and work continues.	Automated emails sent to policy manager advising of those policies due for review within 6-monthly/3 months and overdue in order to initiate reminders.								
Internal	2022-12	Records Management	Unaudited	Director of Digital	Head of Workflow and CO	Medium	R4	a) Local ward clerk shortages will be escalated to the Assistant Directors of Nursing and subsequently escalated to the Executive Director of Nursing. Action plan will be agreed later in the year. b) The clerical bank is undertaking a rolling programme of recruitment which will benefit the short notice requirements for ward clerks and this information will be disseminated by the nursing teams to the ward staff.	A local ward clerk shortage will be escalated to the Assistant Directors of Nursing and subsequently escalated to the Executive Director of Nursing. Action plan will be agreed later in the year. b) The clerical bank is undertaking a rolling programme of recruitment which will benefit the short notice requirements for ward clerks and this information will be disseminated by the nursing teams to the ward staff.	31/07/2023	-11.02	-1462.95	2	August 2024: Meeting with CDO and Director of Nursing has taken place and agreed Ward Clerks will remain under the management of operational areas to ensure ownership and setting ward clerks undertake a range of duties. June 2024: The NMRB process is in place with fortnightly review meetings attended by CDO, senior team to review and manage the process but requires some additional internal resource arrangements to be concluded to support the management of NMRB across the flyleafs from request to final delivery. It requires broader communication to include in the organisation. New request form will be provided on Series ICT Portal in June 2024. Jan-24: First level of organisational process is underway and will commence in February. Rev 23: Will be discussed at Executive Committee and considered as part of the Digital Operational Change Project.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re-structure. Paths now in place and work continues.	No further action on the proposed contribution of ward clerks. However a community of interest will be created with all ward clerks to support improvements in the use of WPMIS and records management.								
Internal	2022-27	Dementia Services	Reasonable	Director of Nursing	Head of Nursing Person Centred Care	Medium	R1	The Standards have been developed and published by Improvement Cyms, there are no National Deadlines set for the Standards. This is continuously evolving and will help to improve standards/regimes to influence shape and improve dementia care over coming years. These are the first 20 Standards and we anticipate that new standards will be introduced by Improvement Cyms over the coming year. We have updated the Board and Quality Patient Safety and Outcomes Committee of work undertaken during the standard year. The Regional Dementia Board considers all the standards which are part of the dementia action plan, and this is also fed back to the Regional Partnership Board. The newly appointed Dementia Programme Manager will oversee all workstreams and, alongside reporting progress, we will report to the partnership board relating to implementing the Standards. Should improvement Cyms produce deadlines, we will meet this recommendation. Additionally, since RHs have been developed per the last 12 months, we will consider how we can best set formal deadlines for reporting. Auditors' comment on management response we agree with the current approach in the context of mandatory deadlines. Therefore, whilst formal deadlines may not be the most suitable approach, we believe that the Health Board should continue to focus on the key principles of the Standards and the implementation of these. However, as this will be closely integrated with performance metrics and current monitoring arrangements, we recommend that exceptions are regularly escalated / reported following the commencement of workstream monitoring by the Dementia Programme Manager.	A local ward clerk shortage will be escalated to the Assistant Directors of Nursing and subsequently escalated to the Executive Director of Nursing. Action plan will be agreed later in the year. b) The clerical bank is undertaking a rolling programme of recruitment which will benefit the short notice requirements for ward clerks and this information will be disseminated by the nursing teams to the ward staff.	01/07/2024	-12.00	-1462.95	0	Closed	6 monthly reporting is sent to Improvement Cyms who report to the Welsh Government DOING (Dementia Oversight, Implementation, & Impact Group). This is also presented to the Gwent Regional Dementia Board. Last presented June 2024.	6 monthly reporting is sent to Improvement Cyms who report to the Welsh Government DOING (Dementia Oversight, Implementation, & Impact Group). This is also presented to the Gwent Regional Dementia Board. Last presented June 2024.								
Internal	2022-27	Dementia Services	Reasonable	Director of Nursing	Lead Nurse Dementia	Low	R4	There should be easily available information / training for staff to ensure patients can communicate with Welsh speaking staff.	The Workforce 4 (Hospital Charter) to link with the Welsh Language Lead and Workforce and Organisation Development leads to identify the number of Welsh Speaking Staff, identify how we can better identify Welsh Speakers and ensure access to Welsh Speakers as part of our Person Centred Care Dementia Care work programme.	01/06/2023	-11.97	31/06/2024	0.00	16/04/2024	Completed / Closed	Completed / Closed	1	July 2024: The Diversity and Inclusion team College including Welsh Language team representatives are members of the Dementia Hospital Learning Group. Language preference and choice have been included on the patient bedside boards introduced to the COTI and medicine wards. The patient Experience and Involvement Team are participating in the Cultural Competency accreditation programme to ensure all activities supported through the team consider cultural awareness and accessibility. Competency certification is expected in August 2024.	July 2024: The Diversity and Inclusion team College including Welsh Language team representatives are members of the Dementia Hospital Learning Group. Language preference and choice have been included on the patient bedside boards introduced to the COTI and medicine wards. The patient Experience and Involvement Team are participating in the Cultural Competency accreditation programme to ensure all activities supported through the team consider cultural awareness and accessibility. Competency certification is expected in August 2024.					
Internal	2023-06	Estates Condition	Unaudited	Director of Strategy, Planning & Partnerships	Divisional Director of Estates and Facilities	High	R1	Management should initiate discussion with NWSOP Specialist Estates Services prior to the next submission of the EPMIS to confirm methodologies for assessment and measurement.	Agreed - the Divisional Director will ensure links with NWSOP prior to any submission of EPMIS data. The timing of this action will be subject to confirmed plans and timelines set by NWSOP for submission although at this point or time, the July 2024 date seems realistic.	31/07/2023	-1.02	-1462.95	0	Aug 2024: Agreed with NWSOP.	Aug 2024: Agreed with NWSOP.									
Internal	2023-06	Estates Condition	Unaudited	Director of Strategy, Planning & Partnerships	Divisional Director of Estates and Facilities	High	R2.2	Planned disposals approved by the Trust Board should be removed from backlog data in accordance with guidance.	Agreed - guidance will be followed. This will be actioned for any future submissions for EPMIS and this timeline will mirror that of R40.1.	31/07/2023	-1.02	-1462.95	0	Currently no Board approved disposals in place but the guidance will be followed.	Currently no Board approved disposals in place but the guidance will be followed.									
Internal	2023-09	Unified Breast Unit at Ystrad Ynnwr Fear	Substantial	Chief Operating Officer	Associate Director of Capital Projects	Medium	4.1	Change control documents should be signed/authorised using a recognised document control process.	Noted - however the HRB does not currently have access to this document control programme. Will be considered for projects including any capital implications. If it is not possible to progress with this, we will continue with manual and ensure the email trail discussion is available for review as per this project.	30/12/2023	-4.02	-1462.95	0	August 2024: The Health Board's position remains unchanged, we still do not have access to document control programs the DocuSign. Instead, we continue to rely on email or meetings for the agreement to sign ICTN. Given the financial constraints, it is unlikely that this will change. Therefore, it is proposed to close this matter on the basis that we have established workstream processes in place that can be audited if required. Health Board does not have access to document control programme (e.g. DocuSign), but continue to use email or meetings as agreement to signing ICTN.	August 2024: The Health Board's position remains unchanged, we still do not have access to document control programs the DocuSign. Instead, we continue to rely on email or meetings for the agreement to sign ICTN. Given the financial constraints, it is unlikely that this will change. Therefore, it is proposed to close this matter on the basis that we have established workstream processes in place that can be audited if required.									
Internal	2023-10	Asset Management	Reasonable	Director of Finance and Procurement	Head of Capital Finance & General Managers	Medium	R2.1	We recommend where assets are disposed of and are not being sold, or where disposal forms are completed retrospectively after an asset has not been found in a physical verification test, that asset owners are required to obtain the deconstruction of their manager on the disposal form.	To ensure all asset disposals are approved appropriately prior to disposal, a counter signature from the General Manager for the Division will be added to the disposal form and the Financial Control Procedure will be amended accordingly. The policy change will need to be reported to and approved by the Audit Committee.	30/04/2024	-4.03	-1462.95	1	August 2024: The Financial Control procedure has been updated to reflect the requirement for Divisional General Manager approval for asset disposals. The change will be considered by the executive team in June and reported to AAC for approval & communicated to all Divisions.	August 2024: The Financial Control procedure has been updated to reflect the requirement for Divisional General Manager approval for asset disposals. The change will be considered by the executive team in June and reported to AAC for approval & communicated to all Divisions.									
Internal	2023-11	Long Term Serious Adverse	Reasonable	Director of Finance and Procurement	Director of Workflow and CO	Low	R1.1	The Health Board should review the Pock to ensure it is up to date and in line with the Health Board's processes and remains fully aligned to the NHS Wales Managing Attendance at Work Policy.	To update the pack, to include the enhanced OH referral process and any other appropriate updates, whilst recognising that the pack predates on the policy, which requires national approval and update.	30/06/2024	-2.03	-1462.95	1	June 2024: Working group led by Kevin Gwyn, Asst Workforce Business Partner established to review and update the resource pack and template letters.	June 2024: Working group led by Kevin Gwyn, Asst Workforce Business Partner established to review and update the resource pack and template letters.									
Internal	2023-17	IT Infrastructure	Reasonable	Director of Digital	Head of IT	High	R5.2	A process for ensuring switches are patched should be established.	ABHHS accept this recommendation. A process for switch patching will be developed and implemented.	31/03/2024	-1462.95	0	June 2024: Partially complete. We do actively perform upgrades across our estates for all infrastructure requirements, following this we will have a patch flow process on how to evaluate published software loads/ free. This needs to be initiated into a SOP and adopted as a operational working process. Target completion June.	June 2024: Partially complete. We do actively perform upgrades across our estates for all infrastructure requirements, following this we will have a patch flow process on how to evaluate published software loads/ free. This needs to be initiated into a SOP and adopted as a operational working process.										
Internal	2023-25	Decarbonisation	Unaudited	Director of Finance and Procurement	Decarbonisation SMO	High	R3.6	Management should ensure the decarbonisation action log is regularly updated.	Agreed - actions are progressing and reflected in minutes but the log needs updating.	30/06/2024	-1462.95	0	ABHHS has more than 80 projects focused on decarbonisation. Not agreed - the Board has considered the need of developing a fully costed decarbonisation plan (as it would require consultancy input) to be unfavourable at the current time, this may be a valid one and available funding can be identified. As a mitigation to allow a consultancy firm has been engaged to provide expertise on options under the netX funding grant e.g. Solar power and will provide options for ABHHS to consider.	ABHHS has more than 80 projects focused on decarbonisation. Not agreed - the Board has considered the need of developing a fully costed decarbonisation plan (as it would require consultancy input) to be unfavourable at the current time, this may be a valid one and available funding can be identified. As a mitigation to allow a consultancy firm has been engaged to provide expertise on options under the netX funding grant e.g. Solar power and will provide options for ABHHS to consider.										
Internal	2023-25	Decarbonisation	Unaudited	Director of Finance and Procurement	Director of Finance and Procurement	High	3.1c	The DAP should clearly set out the actions for achieving the level of carbon emissions reduction required, once calculated.	ABHHS accept this recommendation. A process for switch patching will be developed and implemented.	N/A	-1462.95	0	ABHHS has more than 80 projects focused on decarbonisation. Not agreed - the Board has considered the need of developing a fully costed decarbonisation plan (as it would require consultancy input) to be unfavourable at the current time, this may be a valid one and available funding can be identified. As a mitigation to allow a consultancy firm has been engaged to provide expertise on options under the netX funding grant e.g. Solar power and will provide options for ABHHS to consider.	ABHHS has more than 80 projects focused on decarbonisation. Not agreed - the Board has considered the need of developing a fully costed decarbonisation plan (as it would require consultancy input) to be unfavourable at the current time, this may be a valid one and available funding can be identified. As a mitigation to allow a consultancy firm has been engaged to provide expertise on options under the netX funding grant e.g. Solar power and will provide options for ABHHS to consider.										
Internal	2023-25	Decarbonisation	Unaudited	Director of Finance and Procurement	Director of Finance and Procurement	High	4.1	Management should develop a long-term financial strategy which links to a fully costed DAP to funding available through projections, that provide the largest emissions saving.	ABHHS accept this recommendation. A process for switch patching will be developed and implemented.	N/A	-1462.95	0	ABHHS has more than 80 projects focused on decarbonisation. Not agreed - the Board has considered the need of developing a fully costed decarbonisation plan (as it would require consultancy input) to be unfavourable at the current time, this may be a valid one and available funding can be identified. As a mitigation to allow a consultancy firm has been engaged to provide expertise on options under the netX funding grant e.g. Solar power and will provide options for ABHHS to consider.	ABHHS has more than 80 projects focused on decarbonisation. Not agreed - the Board has considered the need of developing a fully costed decarbonisation plan (as it would require consultancy input) to be unfavourable at the current time, this may be a valid one and available funding can be identified. As a mitigation to allow a consultancy firm has been engaged to provide expertise on options under the netX funding grant e.g. Solar power and will provide options for ABHHS to consider.										
Internal	2023-28	ABHHS Financial Controls - Regional Partnership Board	Unaudited	Director of Finance and Procurement	Assistant Finance Director for Out of Hospital & Partnerships	High	2.1.1	We recommend that the Health Board ensures that clarity is provided by defining the purchase requisition and purchase order process for RFP funding payments, made by the Health Board on behalf of the RFP, indicating the level of detail required to be noted on purchase requisitions and purchase orders. This should include specific reference to the documents that payments may or may not be made to a third sector organisations, and may, or may not, include accruals claimed by the funding recipient where permitted by any funding award letter.	2.1.1 Purchase Order Requisition: Detail included within the purchase requisitions, now include reference to 'Grant Funding'. As well as the relevant funding term. The scheme name continue to be included as a unique identifier. Examples of the orders. This should include specific reference to the documents that payments may or may not be made to a third sector organisations, and may, or may not, include accruals claimed by the funding recipient where permitted by any funding award letter.	30/04/2020	-1462.95	0	This action is complete.	This action is complete.										
Internal	2023-28	ABHHS Financial Controls - Regional Partnership Board	Unaudited	Director of Finance and Procurement	Deputy Director of Strategy, Planning & Partnerships and Assistant Finance Director for Out of Hospital & Partnerships	Medium	2.3.2	We recommend that the Health Board ensures that clarity is provided over the steps to be taken with any financial financial checks and the evidence retention, to ensure Section 6.1 of the Accounts Payable Financial Control Procedure is adhered to.	2.3.2 On receipt of appropriate documentation such as award letters or RFP approval reports, the RFP Finance team are currently responsible for raising requisitions on behalf of the RFP, ensuring that the appropriate governance notes and precedents have been adhered to. The ledger on the system is set up so that the correct financial code is driven by the appropriate funding stream, which is included in the award letters that are issued. However, as noted in section 2.1, to ensure there is a clear differentiation with roles and responsibilities to support the segregation of duties, the process of raising requisitions will be allocated to the PMO Team going forward. Rather than the PMO Finance team.	31/07/2024	-1462.95	0	To ensure there is adherence to Section 6.1 of the Accounts Payable Financial Control Procedures, the purchase order requisitions are now being raised by requisitioners approved by the budget holder. They will ensure that the correct financial code is inserted within the requisition.	To ensure there is adherence to Section 6.1 of the Accounts Payable Financial Control Procedures, the purchase order requisitions are now being raised by requisitioners approved by the budget holder. They will ensure that the correct financial code is inserted within the requisition.										
Internal	2023-28	ABHHS Financial Controls - Regional Partnership Board	Unaudited	Director of Finance and Procurement	Procurement Business Manager	High	4.1	We recommend that the Health Board ensures that the outstanding single tender action is promptly reported to the Audit, Risk and Assurance Committee for their oversight, in compliance with the PMO Financial Control Procedure.	Procurement will ensure that the RFPs referenced are included in the Q2 report for 2024/25 for the Audit, Risk and Assurance Committee.	31/06/2024	-0.98	-1462.95	0	August 2024: Due to be noted at the next Audit Committee on the 12th September 2024	August 2024: Due to be noted at the next Audit Committee on the 12th September 2024									
Internal	2023-28	ABHHS Financial Controls - Regional Partnership Board	Unaudited	Director of Finance and Procurement	Procurement Business Manager	Medium	4.2	We recommend that the Health Board considers an update to the process for reporting and overseeing STAs. In particular, to determine if further financial oversight is required within the STA process.	The STA Template Document has been amended to require sign off from the director of finance before any STA can be awarded, in addition the Procurement team will introduce additional checks to ensure that all STAs undertaken by procurement are noted in the STA register for reporting to the Audit Committee.	31/07/2024	-1462.95	0	August 2024: Action Completed	August 2024: Action Completed										
Internal	2023-29	High Value Patient Transfers	Reasonable	Chief Operating Officer	General Manager	Medium	2.1	We recommend that the Health Board only consider further extensions of the Flow Centre related recommendations by exception only, and that any request to further amend an already revised due date is specifically explained and supported.	As part of the Urgent Care Enhanced Monitoring, this will be actioned as required	31/07/2024	-1462.95	0	August 2024: The progress on the project has been substantial, and a comprehensive update was presented to the Audit, Risk, and Assurance Committee (ARAC) earlier this year. To encapsulate the achievements, Key Performance Indicators (KPIs) have been established to monitor both operational and clinical benchmarks. A robust business continuity plan was initially formulated on January 2024, and has since undergone several refinements, with the latest version dated August 15th. This plan has been rigorously evaluated through risk incidents, and the insights gained from these events have been systematically integrated into the review cycle, with specific incidents being considered and fully formally concluded.	August 2024: The progress on the project has been substantial, and a comprehensive update was presented to the Audit, Risk, and Assurance Committee (ARAC) earlier this year. To encapsulate the achievements, Key Performance Indicators (KPIs) have been established to monitor both operational and clinical benchmarks. A robust business continuity plan was initially formulated on January 2024, and has since undergone several refinements, with the latest version dated August 15th. This plan has been rigorously evaluated through risk incidents, and the insights gained from these events have been systematically integrated into the review cycle, with specific incidents being considered and fully formally concluded.										
Internal	2023-32	LINC Programme	Reasonable	Director of Digital	Pathology Directorate	High	1.1	Management should ensure that risks 8795 and 7002 are reviewed, updated, and managed accordingly.	8795 and 7002 are duplicate risks. 8795 has been closed. 7002 remains on the directorate risk register and has been reviewed and updated and will be subject to monthly review and update.	31/05/2024	-1462.95	0	07/24 - Risk 8795 closed as duplicate. Risk 7002 reviewed and updated and governance reviewed. Monthly directorate risk meetings in place to manage ongoing monitoring of risk. Joint risk review between directorate and O&A duplicated as formal monthly meetings.	07/24 - Risk 8795 closed as duplicate. Risk 7002 reviewed and updated and governance reviewed. Monthly directorate risk meetings in place to manage ongoing monitoring of risk. Joint risk review between directorate and O&A duplicated as formal monthly meetings.										
External	2023E4	Primary Care	Not Rated	Chief Operating Officer	Director of Primary Care and Community Services	N/A	R3c	Review the way it currently reports to Board and committees on its progress in delivering its plans for primary care, and importantly, how it's reporting on improved outcomes for patients in primary care	The Division has monthly assurance meetings with their Executive Director. The Division also provides information at mid and full year to the Board.	August 2024	-1462.95	0	August 2024: Progress to date. The Primary & Community Care Division is integrated into the governance and reporting frameworks of ABHHS. The division contributes to the integrated monthly performance report and has been the focus of in-depth reviews by the executive team/board for areas requiring additional scrutiny or comprehension.	August 2024: Progress to date. The Primary & Community Care Division is integrated into the governance and reporting frameworks of ABHHS. The division contributes to the integrated monthly performance report and has been the focus of in-depth reviews by the executive team/board for areas requiring additional scrutiny or comprehension.										
External	2023.06E4	Primary Care Follow up	Not Rated	Director of Corporate Governance	N/A	N/A	R3.2	b) Review the frequency with which Board and committees receive performance reports regarding primary care	The Primary Care Division will be updating the Health Board at the April Development session to report on progress against the sustainability workstream.	30/04/2024	-1462.95	0	August 2024: Progress to date. The Primary & Community Care Division is integrated into the governance and reporting frameworks of ABHHS. The division contributes to the integrated monthly performance report and has been the focus of in-depth reviews by the executive team/board for areas requiring additional scrutiny or comprehension.	August 2024: Progress to date. The Primary & Community Care Division is integrated into the governance and reporting frameworks of ABHHS. The division contributes to the integrated monthly performance report and has been the focus of in-depth reviews by the executive team/board for areas requiring additional scrutiny or comprehension.										

Audit Type	Reference and Ref.	Report Title	Assessment Status	Director	Responsible Officer	Priority	Recommendation Number	Recommendation	Management Response	Start/In Agreed in First Report	Monthly progress Agreed Deadline	Proposed Revised Deadline	Monthly progress Revised Deadline	Date Revised Deadline re- agreed to other Committee	Final Report Deadline Status	Revised Deadline Status	Number of revised Timescales Requested including: new request	If closed and not complete please provide justification and ensure evidence is available	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close/complete the recommendation?
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital	N/A	R1	R1 The governance framework for IM&T / digital should be clarified and where control over aspects of IM&T has devolved to departments, there should be a process for these to feed into the relevant Committee to ensure oversight. Underneath the Committee the steering group remit and membership should be defined.	Agreed. The Health Board is establishing a new governance framework. Currently Informatics is reporting to the Audit Committee, the first report is scheduled for 8th April. A Health Board governance framework is in development for Informatics including exec oversight, investment and delivery. The management of the global pandemic has disrupted the planning work by 12 months but this is now re initiated. Recommendations are scheduled to be presented to Exec Team Q1, and Board in Q2.	30/06/2021	-17.97	31/08/2024	0.00		Overdue	Overdue	5		August 2024: The clinical council will report into the wider Health Board's clinical advisory group so terms of reference now being reviewed to note this change.			
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital / Assistant Director for Strategy, Planning & Design	N/A	R5	R5 The Health Board should ensure greater links with divisions and the Informatics Directorate. The Informatics Directorate should be involved in the decision making process for all IM&T items.	Accepted. The CDO will present the recommended Target Operating Model to the HB which will include governance over Informatics as a Division and also departmental systems. Part of the framework will include decisions to procure and assurance processes not only for Informatics division but Informatics services owned outside. Part of adoption will help appraise strategic options in how the HB wishes to take this forward. Part of the ISO objectives will set out the responsibilities for devolved asset owners and a performance management framework to identify risk and provide oversight. There is likely to be a resource impact in achieving this which will be subject to a business case.	31/03/2021	-40.95	30/09/2024	0.98		Overdue	Overdue	4		August 2024: agreed format for Divisional Meetings with Mental Health, Families & Therapies and Medicine. Anticipate meetings will be in place by end of Q2			
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital / Assistant Director for Strategy, Planning & Design	N/A	R9	R9 A network of champions across the organisation should be established. The Digital Strategy should be reviewed alongside the roadmap. This should form the basis for engaging the network of champions to drive the Strategy forward.	Accepted The Channel 3 report also identified a need for more emphasis on Clinical Leadership, Design and Business Partnering. This is subject to additional investment although recently the appointment of a full time CMO/CDO has been a significant step forward. Duwethy the Directorate recommendations will be presented to Execs on overarching exec level oversight which is intended to both strengthen accountability but also to ensure Informatics capacity is used to best effect. Benefits realisation training has commenced in Informatics and will form part of reporting. It is in principle agreed that the Health Board adopts a single methodology and framework that should be co produced to manage all priority investments.	30/09/2021	-14.95	31/10/2024	2.00		Overdue	Overdue	4		"August 2024: Digital Champions in place through the MS65 Team. Business partnering to be reviewed by Ooat Senior Leadership Team"			
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital	N/A	R13	R13 Critical assets should be identified within the asset and configuration management systems.	Agreed. This is in part due to the devolved nature of Informatics. The first step will be presenting the new operating framework's overarching governance recommendations will provide oversight. A strategy, policy and resultant business case will be developed following the Health Board adoption of the reviews recommendations.	31/12/2021	-31.93	31/07/2025	10.95		Overdue	Overdue	4		August 2024: A review of the cyber security plan and Information Asset Register has identified significant work remains to understand critical assets across the estate alongside the new security platform mentioned in the			
Internal	2021.12	IT System Controls (WMS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R7	R7 The success of the use of the leavers list should be monitored to ensure that it works as anticipated and that all leaver accounts are removed on a timely basis.	We monitor this as much as possible in Radiology. We have recently started receiving consultant leaver's/slots from the Health Board and action these also. The success of the process will be tracked and evaluated to ensure it is working.	30/04/2022	-28.00	01/12/2025	14.98		Overdue	Overdue	3		Aug 2024: We are still limited to users outside of Radiology but there is communication for those internal to Radiology though it's not automated and dependant on people informing us of this. Outside of Radiology IT should disable their account in AD which will disable their access to the Healthboards systems. The new RIS/PACS access is dependant on being added to the appropriate AD groups which will be disabled when they leave the Healthboard.			
Internal	2021.12	IT System Controls (WMS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R8	R8 The Health Board should request that this tagging function be developed and should consider feeding WMS events into the SIEM.	The health board have raised this at DHCW CAB along with other health boards. This is with DHCW to develop it is not in any Live RadS version currently.	31/03/2022	-28.98	01/12/2025	14.98		Overdue	Overdue	3		Aug 2024: There is no adequate audit functionality within RadS and with the product being soon end of life there will be no solution until the new PACS/RIS is in place which has thorough audit functionality.	Time and resource in RadS. As well as pending RSP program may not help development.		
Internal	2021.12	IT System Controls (WMS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R9	R9 A formal disaster recovery plan for WMS should be developed.	The Disaster recovery plan is to fall over to a mirrored system however, since the upgrade this needs to be re-visited and formally set out. ABUSB have a VMware environment where this is hosted. The Radiology departments have disaster recovery by using emergency jacks in each department and a policy that explains how to use these emergency jacks in a RadS downtime scenario.	30/04/2022	-28.00	01/12/2025	14.98		Overdue	Overdue	3		Aug 2024: We don't have a mirrored DR system in place for PACS or RIS. We would still be dependant on setting up mini-PACS at each site which is time consuming and not a true DR system. The new PACS/RIS will be predominantly cloud based with short term storage and full functionality of our PACS in RIS in our DC in GUW and a smaller backup in our YAG DC. With the fibre connection between both DC the VLAN should stretch and we could have a true DR system for continuity.	Aug 2023: Time and resource in RadS. As well as pending RSP program may not help development.		
Internal	2022.11	Policies	Unrated	Director of Corporate Governance	Head of Corporate Governance	Low	R3	R3 The Health Board should consider the relevant Health and Care Standards when reviewing / updating a policy or other relevant documentation. An acknowledgement of this process should be included, together with the titles of the relevant Standards included.	The introduction of the Duty of Quality, under the Health and Social Care (Quality and Engagement) (Wales) Act 2020, will see the Health and Care Standards (April 2013) removed and replaced with Quality Standards 2023. As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), the introduction of the Quality Standards 2023 will be considered, and policy templates updated as they are reviewed/developed.	29/09/2023	-11.00	31/10/2024	2.00		Overdue	Overdue	4		August 2024: Policy Management Framework to be presented to Board September 2024 (finalised and scheduled). This was deferred from July 2024 due to engagement with staff groups on the content.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues		
Internal	2022.11	Policies	Unrated	Director of Corporate Governance	Head of Corporate Governance	Medium	R4	R4 The Health Board, alongside recommendation 3.1 should consider automating the submission of a policy from the responsible owner, to ensure that a consistent submission format is adhered to.	An integrated electronic policy management system will be explored, learning from other health bodies, with an implementation plan developed to support the most appropriate system.	29/09/2023	-11.00	31/10/2024	2.00		Overdue	Overdue	4		August 2024: Partially complete. SharePoint system in place and automated flagging and reminder system established. / Review of templates and submission process included within the revised Policy Management Framework scheduled for submission to Board in September 2024.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues		
Internal	2022.11	Policies	Unrated	Director of Corporate Governance	Head of Corporate Governance	Medium	R1	R1 The Health Board should review the types of policy documents retained and hosted, to determine if each of them should adhere to the Policy, for example, departmental standard operating procedures to be managed entirely within the respective division. Alongside this review, the document owner should be determined to ensure the responsibility remains with the most appropriate individual.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), clarity will be provided on which WCDs are to be held centrally and which are to be managed within services and teams. A review of the central base (B81 documents) is underway, working with divisions, to review the status of each document and respective owners.	31/03/2023	-17.02	31/10/2024	2.00		Overdue	Overdue	4		June 2024: Clarification of definitions of WCDs and Health Board vs local documents included within the revised policy framework, to be presented to Board in July 2024.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues		
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Assistant Director for Strategy, Planning & Design	Low	R1	A formal SOP should be defined that sets out how the RPA process is to be managed. The operational service model should be fully defined and the terms of reference for the governance board reviewed and updated.	Upon successful investment case being made this will be addressed as part of the transition to service delivery	01/06/2023	-14.98	31/12/2024	4.00		Overdue	Overdue	4		August 2024: Work on the delivery model has been delayed due to a focus on transitioning all existing automations onto a new BPC platform as part of essential maintenance work to secure a sustainable service. It is expected that the operational delivery model will be completed by the end of the calendar year.			

Information supplied to the Audit Risk and Assurance Committee in July					
Report Title	Recommendation	Management Response	Agreed Deadline Date	Progress Update Provided in June	If NOT completed, please provide a date in which you expect to complete
Medical Equipment and Devices (2017/18) R1 Limited Assurance High Recommendation	Registers should be maintained for operational management of medical devices and equipment on each ward and department, which should record relevant equipment details. The register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed. Each area should ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record it upon the register. Discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded. Going forward, relocation of equipment, disposals, additions etc. should be updated promptly to ensure an accurate record continues.	The Health Board to consider investing in an overarching equipment database register with staff resources to ensure regular updating and management.	30/04/24	The EBME Service will be in a position to issue the user guide for the Medusa Customer Portal following the delayed major update to the Medusa database that is scheduled to be implemented on 12th July 2024. The ward and departmental audit of non-electrical medical equipment has been implemented. The output will be a local inventory/register of installed medical equipment not captured in other databases. This is generally non-electrical equipment	05/08/24
Medical Equipment and Devices (2017/18) R2 Limited Assurance High Recommendation	A clear robust control mechanism should be established by the divisions / directorates demonstrating the consideration and delivering of applicable training aligned to medical equipment and devices. Training records should also be uploaded onto ESR. The poor mandatory training compliance rates with regard to infusion devices / pumps should be addressed as a matter of urgency.	From a Divisional perspective, the cascade training provided at ward level has not raised any particular safety issues, although with the increasing use of bank and agency staff, consideration should be given to accessible on-site training for these members of staff. The Health Board to consider establishing a catalogue of equipment that needs specific training to operate, alongside a database of staff compliance.	31/05/24	A system of providing centralised training to cascade infusion device trainers has been established and training is in now workstream. A system of categorisation of the degree of training required against groups of equipment types has been developed. Reflection of this in the Medusa equipment management database is pending the major update that is scheduled to be implemented on 12th July 2024. Representation of the centralised essential-for-job-function training competencies in ESR is pending engagement sought from the ESR team.	31/08/ 24

Both recommendations have been completed since the report to the Committee in July. The updates below provide evidence of completion.

Report Title	Additional Information to be Supplied to the Audit Risk and Assurance Committee	Status
Medical Equipment and Devices (2017/18) R1 Limited Assurance High Recommendation	<i>Registers should be maintained for operational management of medical devices and equipment on each ward and department, which should record relevant equipment details</i> A centrally managed industry standard pan-organisation medical equipment register is in place and operational. The equipment Register was reported as operational in the 2022 Audit Review <i>The register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed</i> The dataset, structure and format of the register allow centralised oversight of operational equipment management within the EBME service. There is a system in operation for reviewing the accuracy of data. <i>Each area should ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record it upon the register</i> The delayed MEDUSA upgrade has now taken place. The EBME team are clear on how the updated version operates and have written user instructions accordingly. The user instruction is being rolled out to wards and departments with an offer of user support until such time as users are conversant with the MEDUSA customer portal The benefit of utilising this system at ward/departmental level is that stock/inventory lists of electrical devices can be downloaded from the central stock database for auditing purposes on a regular basis. The non-electrical medical devices audits have been implemented across the healthboard to identify non-consumable, non-electrical medical devices. The roll-out of user instructions was completed by August 5th. The actions required to provide assurance on this recommendation, R1, can now be considered closed <i>Discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded</i> There is a programme of periodic register accuracy reviews and of auditing the review processes. A mechanism is in place for ward and departmental managers to audit the equipment deployed in their work areas against the register and to report discrepancies for corrective action. <i>Going forward, relocation of equipment, disposals, additions etc. should be updated promptly to ensure an accurate record continues</i> The Medusa database captures equipment lifecycle stage events and changes to the departments to which particular equipment is allocated. Deployment location updates rely on manual reporting by ward and departmental managers or by routine data verification by EMBE or Finance's routine Asset Management activities. This will be automated on full implementation of RF asset tracking of equipment. Future monitoring/audit will continue using MEDUSA and physical observations audit until such time as the RFID asset tracking system is fully rolled out	COMPLETED
Medical Equipment and Devices (2017/18)	<i>A clear robust control mechanism should be established by the divisions / directorates demonstrating the consideration and delivering of applicable training aligned to medical equipment and devices</i> Medusa has been populated with user training requirements by generic model group. Ward and departmental managers can cross reference the models of equipment in use in their respective areas with members of staff that are required to use them. They can use this information to plan the appropriate training courses through ESR.	COMPLETED

R2 Limited Assurance High Recommendation	<i>Training records should also be uploaded onto ESR</i> The fourth category of the high-risk centrally managed periodic training courses and training records in relation to Infusion Devices is now being managed in ESR. Safety is underpinned by the fact that staff are bound by their scopes of professional practice and the scrutiny of their professional qualifications by their respective professional and line managers to ensure they are appropriately trained to undertake the tasks they are directed to do; this includes appropriate assignment of Bank Staff - more comprehensive functionality in ESR will streamline this assurance processes further. <i>The poor mandatory training compliance rates with regard to infusion devices / pumps should be addressed as a matter of urgency</i> Significant work and effort have been carried out since the infusion devices training manager came into post 18 months ago. Up until that point, progress against raising compliance was very difficult to achieve. There was also a large post-Covid decrease in the number of trained staff. The measures that have subsequently been put in place since the recruitment have proven extremely effective and resulted in a significant compliance increase from 39% in 2017 to 89% in July 2024 (current standard is 70%).	

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	12 September 2024
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Update on Single Quotation and Tender Actions –23rd March 2024 to 29th August 2024
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Finance, Procurement and Value Based HealthCare
SWYDDOG ADRODD: REPORTING OFFICER:	Alex Curley – Head of Procurement

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA

SBAR REPORT

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

Appendix A provides specific detail regarding the Single Quotations / Actions that have been submitted and approved for the period 23rd March 2024 to 29th August 2024.

Cefndir / Background

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

consideration. The Audit, Risk and Assurance Committee's work plan includes a standing item for review of the following at each meeting:

- Review of Single Quotation and Tender Requests.

Asesiad / Assessment

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

There have been 11 requests submitted which have been approved during the period with an annual value of £1,246,110.95 Ex VAT.

Of these 11 approved requests, 10 were classified as services with 1 approved as goods type arrangements.

There are also 5 service type agreements which were put in place all at the same time that were missed previously so are being included in this report for reference. These 5 agreements totalled £443,540.00 and are included at the end of appendix 1 in bold, dated 24/03/23.

These agreements were recently identified following an audit of RPB payments. The audit found that whilst the STA's had been signed and approved in line with the correct governance, the STA's had not been reported to the Audit, Risk and Assurance committee for oversight and that this should be done at the earliest opportunity. Additional checks have been put in place within the procurement team to ensure STA's are included in the report in a timely manner.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to note the content of this report for assurance.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a
Sgôr Cyfredol:
Datix Risk Register Reference
and Score:



Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Finance Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper Choose an item.
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk



**Deddf Llesiant
Cenedlaethau'r Dyfodol – 5
ffordd o weithio
Well Being of Future
Generations Act – 5 ways
of working**

<https://futuregenerations.wales/about-us/future-generations-act/>

Choose an item.
Choose an item.



Appendix A - Summary of Single Tender/Quotation Actions											
Date of Request	Type of Request	Reference No	Description	Anticipated Annual Value (ex VAT)	Supplier	Type	Reason for request	Advice from Procurement	Approved / Rejected	CEO & DoF Approval Date	Chairs Approval Date (If Applicable)
10/04/2024	Single Tender Action	ABU-STA-55787	Rainbow Connectors	£95,000.00	Growing Space	Services	Growing Space, will provide the Rainbow Connector's (RC) service via three members of staff (the Rainbow Connectors) to provide specific ad hoc support for people who may be struggling with anxiety, accessing community support/services and/or activities, post discharge from Adult inpatient units and/or CMHT's and aims to support people to remain stable. A VEAT notice has been published with information of the single supplier, we didn't receive challenges or potential bidders for the service within the stand still period. The Rainbow Connectors service is being included in the Tender 'Alliance Commissioning Approach' project which the planning phase has started with procurement, so this STA is to put compliance in place until the Alliance contract starts.	A VEAT Notice has been issued to the market to inform them of our intention to award without the call for competition and no challenge has been raised to that approach and no further bidders came forward. The intention is to award a contract until end of March 2025 by which time there will be a wider competition as part of the Alliance approach being developed with the division.	Approved	22/05/2024	
21/05/2024	Single Tender Action	ABU-STA-56389	PHM Platform	£35,000.00	DiIS at Dorset County Hospital FT – Heather Case Williams Ave	Services	This is to build the infrastructure and platform to test the concept of population health management which in turn has the aim of better managing and supporting the people of Gwent to keep them well and healthy. A healthier Gwent could potentially have a positive financial impact across health services within Gwent and this could be evaluated within this smaller proof of concept project. In addition, this will support the building of the national data resource and put Aneurin Bevan University Health Board in a well placed position to compliment the implementation of the national data resource and the WG PHM framework	The agreement is to purchase knowledge and expertise which is currently only available from within Dorset NHS Foundation Trusts as leaders in this particular field.	Approved	21/05/2024	
01/08/2024	Single Tender Action	ABU-STA-56962	Honeywell EBI Upgrades	£143,975.95	Honeywell	Services	Work Required 1)EBI Upgrades- Design, supply, test, and commission a migration of EBI version R500 to the latest version EBIR700. 2)Pharmacy BMS Controller Upgrade – Removal of two existing BMS Controllers and replacement with new C&E Jace-8000 controller, including software development and commissioning and new graphics. 3)Generator Network Upgrade – Upgrade of three BMS controllers that are used to monitor the generator at Royal Gwent Hospital, including development of new software. The BMS system/s are closed protocol, and there are no other suppliers of the system software.	The STA is an appropriate course of action given that the curen system is the Honeywell System and they are the only provider able to update their own system.	Approved	07/08/2024	
27/03/2024	Single Tender Action	ABU-STA-137954	Gwent Connect 5 Training 4 Training (T4T) - Newport Mind	£10,200.00	Newport Mind	Services	The Gwent Connect 5 training programme delivery plan requires the support of Lead Trainers for 2024-25. The reason for this single supplier request (and the associated single supplier request for Newport Mind) is due to 4Minds (and Newport Mind) being the only trained Gwent Connect 5 Lead Trainers available for 2024-25. As this funding is for one year, there would not be the time and it would not be cost effective to recruit and train additional Lead Trainers. The alternative delivery model would be to commission Connect Collaborations (the owner of Connect 5) to deliver the T4T – this would be more expensive and divert WG funding outside of the Aneurin Bevan locality, to England.	This is one of only two providers who are accredited to provide this training. Both providers will be required in order to meet the requirements of the Health Board	Approved	11/06/2024	
27/03/2024	Single Tender Action	ABU-STA-137955	Gwent Connect 5 Training 4 Training (T4T) - 4 Minds	£10,200.00	4 Minds	Services	The Gwent Connect 5 training programme delivery plan requires the support of Lead Trainers for 2024-25. The reason for this single supplier request (and the associated single supplier request for Newport Mind) is due to 4Minds (and Newport Mind) being the only trained Gwent Connect 5 Lead Trainers available for 2024-25. As this funding is for one year, there would not be the time and it would not be cost effective to recruit and train additional Lead Trainers. The alternative delivery model would be to commission Connect Collaborations (the owner of Connect 5) to deliver the T4T – this would be more expensive and divert WG funding outside of the Aneurin Bevan locality, to England.	This is one of only two providers who are accredited to provide this training. Both providers will be required in order to meet the requirements of the Health Board	Approved	11/06/2024	
27/03/2024	Single Tender Action	ABU-STA-5760	Acron Project	£835,937.00	Thrive (United Wales HA)	Services	Retrospective contract award that has been identified as the supplier needed paying - agreement set up until November 2024 to allow for a review and formal process to take place.	Not endorsed by procurement as retrospective request - STA has been signed off by the Board to allow for payment to the supplier and a formal procurement process will take place before November 24.	Approved	18/04/2024	
04/04/2024	Single Tender Action	ABU-STA-56076	Palliative Care Consultant Virtual Support	£48,000.00	Supportive Care UK (SCUK)	Services	Extending virtual support from Palliative Care Consultant (Supportive Care UK) to support ABUHB Clinical Nursing Specialist (Specialist Palliative Care) for maintaining service at the Royal Gwent Hospital. This consists of virtual board rounds, telephone advice, support, education and training. The Directorate have been unable to recruit to Palliative Medicine Consultant posts and due to capacity, were unable to maintain services on all AB sites and there explored alternative options in order to maintain a Specialist Palliative Care to support RGH.	Alternative options have been explored by the division but nothing suitable could be found so it is agreed that an STA is appropriate for this requirement. The request is retrospective as the requirement dates back to January this year so it cannot be endorsed due to it being retrospective. The procurement team will however seek to establish an agreement back dated to January. The division should contact the procurement department well in advance of any known requirement to ensure the procurement team has sufficient time to explore all options and ensure appropriate governance.	Approved	11/04/2024	
15/05/2024	Single Quotation Action	ABU-SQA-20240118-001	Chemical Storage Cabinet - Mobile DeCon Unit	£8,990.00	NEOCARE Ltd	Goods	New equipment to support the Mobile decontamination unit. Purchase 1x new Double Peracetic acid Storage Cabinet for the temporary endoscopy unit. Neocare Ltd are the OEM and this storage cabinet is the only cabinet that has been designed and manufactured with Getinge, for the safe storage of their chemicals, due to the unique design of the bottles that fit into the EWD's (Endoscope Washer Disinfector's).	As the only supplier of this bespoke equipment the SQA is an aproprate course of action.	Approved	15/05/2024	
15/05/2024	Single Quotation Action	ABU-SQA-137953	Yalla Cooperative	£18,882.00	Yalla Cooperative	Services	This is a continuation of a successful working relationship with Yalla Cooperative. To develop a similar Booking and Evaluation Tool with another provider would not be value for money. The current Booking and Evaluation Tool has been tailored for Gwent. Good working relationships have already been established and ABUHB benefit from Yalla Cooperative's learning and experience from previous work and ongoing work with similar projects.	This system/application has been specifically developed to meet the requirement of this service and as such there is no alternative currently available to meet these specific requirements.	Approved	22/05/2024	
15/05/2024	Single Quotation Action	ABU-SQA-142305	Living Life to the Full Microsite	£24,626.00	Five Areas Limited	Services	Five Areas Ltd developed this bespoke microsite for ABUHB/Melo in 2021, and their resource and courses have been accessible through Melo since that date. The microsite contains a wide range of selfhelp resources and courses based on Cognitive Behavioural Therapy (CBT) approaches to help people improve their mental wellbeing. Data indicates that the take up of these resources continues to increase each financial quarter and is linked to increased communications and engagement activity. Five Areas Ltd designed and developed the Living Life to the Full resources. These resources are high quality, accessible and use award winning, practical (CBT) based education life skills. The resources have been developed for members of the public to help them help themselves.	This provider is the only supplier who can provide this site	Approved	22/05/2024	
29/04/2024	Single Quotation Action	ABU-SQA-56218	Fact Finding Review	£15,300.00	Fiona Myers	Services	The Health Board requires the services of a highly-specialist, independent reviewer with substantial Chief Executive level experience who is wholly independent of the NHS in Wales and possesses expert knowledge of Mental Health services to undertake a highly sensitive fact-finding review in line with an agreed Terms of Reference.	Given the urgent and unforeseen need for this review to take place it is considered that an SQA is appropriate to ensure that the review can take place in a timely manner. Running a procurement process for this would likely cause delays to the review being undertaken and potentially lose out on the skills of the individual who is currently available to undertake the review	Approved	26/04/2024	

24/03/2023	Single Tender Action	ABU-STA-137081	Site Redevelopment	£20,000.00	Sirius	Services	With the inception of additional capital policy guidance and associated funding provided to regional partnership boards there is a requirement to develop a 10 year strategic capital plan by 31st of July 2023. With the current investment levels available all net proportionate basis of at least £20 million per financial year it can be assumed the value of a 10 year strategic capital plan could reach 200 million in capital infrastructure investment for Gwent. Following JPB share approval to signal drawdown of the funding to Welsh government against an outline plan on 23rd February 2023 known consultancy's who have either worked within the region or are working with in other regions on the same subject area of strategic capital plan preparations for regional partnership boards have been engaged with. TPB have approved the Commission of the work on 14th of March 2023 meeting.	Approved as this Commission relates to a time limited specific work package to aid the development of the TPB 10 year strategic capital plan no further financial implications will be realised. Applies across ABU-STA-137081, 83, 84, 85 & 86	Approved	29/03/2023	
24/03/2023	Single Tender Action	ABU-STA-137083	HICO Population Needs Assessment	£105,600.00	HICO	Services	Consultancy services to provide the following - Review of available evidence from population needs market stability and area plan. Strategic needs assessment literature review quantitative analysis and qualitative analysis for the following population groups. -People with hoarding disorder -People with physical disabilities phase one data gathering desktop analysis identification of further data requirements phase two completion of quantitative analysis and undertaking qualitative analysis where it will add value or address any gaps in data provision	Approved as this Commission relates to a time limited specific work package to aid the development of the TPB 10 year strategic capital plan no further financial implications will be realised. Applies across ABU-STA-137081, 83, 84, 85 & 86	Approved	29/03/2023	
24/03/2023	Single Tender Action	ABU-STA-137084	Strategic Needs Assessment	£25,500.00	Oxford Brooks	Services	Strategic needs assessment (literature review, quantitative analysis and qualitative analysis) for the following population groups: Older People with Complex Needs (to be undertaken collaboratively with Attain) Phase 1: Data Gathering, desktop analysis, identification of further data requirements (March 2023 activity) Phase 2: Completion of qualitative analysis, and undertaking of qualitative analysis where it will add value/address any gaps in data provision (April/June activity) Collaboration capacity across Phase 1 and Phase 2 to ensure complementary alignment, shared approaches, consistent templates, across all consultancy organisations supporting undertakings related to RPB strategic capital preparations	Approved as this Commission relates to a time limited specific work package to aid the development of the TPB 10 year strategic capital plan no further financial implications will be realised. Applies across ABU-STA-137081, 83, 84, 85 & 86	Approved	29/03/2023	
24/03/2023	Single Tender Action	ABU-STA-137085	Project Management	£97,500.00	Sirius	Services	Programme & Project Management capacity to enable the collaborative approach across four independent organisations working on separate population groups/work packages, ensuring delivery against milestones, quality assurance of outputs, regular progress reporting, and production of single package of information (provided by three other organisations) A phased approach will be implemented, reflective of the two funding streams enabling the strategic plan preparations: Phase 1 - 2022-23 IRCF Revenue (March 2023 activity), Phase 2 - 2023-24 ICF Capital legacy fund (April — June activity).	Approved as this Commission relates to a time limited specific work package to aid the development of the TPB 10 year strategic capital plan no further financial implications will be realised. Applies across ABU-STA-137081, 83, 84, 85 & 86	Approved	29/03/2023	
24/03/2023	Single Tender Action	ABU-STA-137086	Strategic Needs Assessment	£194,940.00	Attain	Services	Consultancy services to provide the following strategic needs assessment for the population groups. -Older people with complex needs -People living with dementia -People with learning difficulties -People with mental health conditions -Children with complex needs Phase one data gathering desktop analysis phase two completion of analysis quantitative & qualitative analysis collaborative and project management capacity across phase one unfazed too to ensure complementary alignment shared approaches consistent templates across all consultancy organisations supporting undertakings related to RPB St strategic capital preparations	Approved as this Commission relates to a time limited specific work package to aid the development of the TPB 10 year strategic capital plan no further financial implications will be realised. Applies across ABU-STA-137081, 83, 84, 85 & 86	Approved	29/03/2023	

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	12 September 2024
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Financial governance, reporting & control.
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Robert Holcombe, Director of Finance, Procurement and Value Based HealthCare
SWYDDOG ADRODD: REPORTING OFFICER:	Mark Ross, Assistant Finance Director

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

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

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

The Audit, Risk and Assurance Committee is requested to:

- Note the contents of this report.



- Approve the updated financial control policy and procedures.

- Salary Sacrifice (Appendix 1)
- Out of Area Referrals to Secondary Care (Appendix 2)

Cefndir / Background

Financial control procedures are reviewed, as a minimum, on a 3 yearly basis.

The FCPs presented were considered and approved by the Executive Committee at their meeting on the 24th of August and are presented to the Audit, Risk and Assurance Committee for approval.

A table has also been included to provide an update of the status of all financial control procedures.

Asesiad / Assessment

1.Financial Control Procedures (FCP)

The FCPs to be reviewed at this Committee as part of the regular programme of updates are:

- Salary Sacrifice (Appendix 1)
- Out of Area Referrals to Secondary Care (Appendix 2)

A summary of the main changes to each of the Financial Control policy/procedure is set out below. The full revised FCPs are included in Appendix 1 - 2.

1. Salary Sacrifice

Owner: Director of Finance, Procurement and Value
Review Date: August 2024

Aneurin Bevan University Health Board operates a number of salary sacrifice schemes for the benefit of its staff members.

To facilitate salary sacrifice schemes, the Health Board will generally make payment to the supplier for goods and/or services and recover the costs from members of the scheme, over the course of the salary sacrifice agreement.

The procedure provides a framework to ensure effective financial controls are in place for setting up a new scheme, managing and renewing existing schemes.

The document has been circulated for comment as follows:

- CMA Team Leader
- Head of Financial Services & Accounting



- Head of Workforce Planning
- NWSSP - Audit and Assurance Services

Main changes to the document

Paragraph	Summary of change
All	Organisational change - Director of Finance changed to Director of Finance, Procurement and Value.
All	Intranet links added for internal documents/external websites
Appendix 1 (1.1)	Corporate Finance – Clarification of responsibility ie ensuring Payroll deduct correct amounts; VAT is being treated correctly; savings are reflected in the correct cost centre
Appendix 1 (1.1)	Payroll – PAYE arrangements – Clarification of responsibility ie create calculation and reconciliation
Appendix 1 (1.1)	Deductions from salary – Fleet Services scheme added with responsibility sitting within Shared Services
Appendix 1 (1.1)	Deductions from salary – Home Technology scheme added with responsibility sitting within Shared Services
Appendix 1 (1.1)	Deductions from salary – Pensions scheme added with clarification of understanding ie relates to the option for employees to seek pension advice, which can be paid via salary. It is <u>not</u> in relation to where employees can pay more into their pension and responsibility sitting within Shared Services
Appendix 1 (2)	Clarification of Process – In reference to monitoring financial performance of schemes, the process of creating a new cost centre, which also defines the reconciliation responsibility, has been added

2. Out of Area Referrals to Secondary Care

Owner: Director of Finance, Procurement and Value
Review Date: August 2024

The procedure outlines Aneurin Bevan University Health Board's approach for providing and commissioning secondary care services for the residents of Newport, Torfaen, Monmouthshire, Caerphilly, and Blaenau Gwent (Gwent Residents) and English residents registered with a Welsh GP (Cross Border Residents).

The procedure ensures the organisation has a systematic and planned system in place to:

- Plan and secure secondary care services.
- Make appropriate arrangements for the provision of care.



- Enable the Health Board to make clear decision-making regarding where an individual patient receives their treatment.

The document has been circulated for comment as follows:

- Finance Contract and Performance Manager
- Assistant Finance Director (Financial Strategy and Planning)
- NWSSP - Audit and Assurance Services

Main changes to the document

Paragraph	Summary of change
All	Organisational change - Director of Finance changed to Director of Finance, Procurement and Value.
2.1, 5	Name Change – Clinical Commissioning Group (CCG) updated to Integrated Care Board (ICB)
8.2	Clarification of Process – In reference to the review panel meeting within 28 days of receiving a request, the wording 'subject to the availability of the Non-Officer Member' has been added
8.2	Clarification of Process – In reference to the review process, the wording 'There is no further right of appeal' has been added

The table below provides an update regarding the review dates for all of the Financial Control Procedures.

Summary Position on Financial Control Procedures

FCP	Year Due	Approved	Committee Approved	Review Date	Notes
Approval of Orders over £100K	23/24	Due for review	Feb-21	04-Feb-24	On hold until SoD Approved
Salary Sacrifice	24/25	Due for review	Aug-21	12-Aug-24	Scheduled for Sept 24
Policy for Out of Area Referrals to Secondary Care	24/25	Due for review	Aug-21	12-Aug-24	Scheduled for Sept 24
Overseas Visitors	24/25	Y	Feb-22	03-Feb-25	
Charitable Funds	25/26	Y	Apr-22	19-Jul-25	
Recovery of Overpayments to Employees	25/26	Y	Aug-22	02-Aug-25	
Budgetary Control Policy & Procedure	25/26	Y	Aug-22	02-Aug-25	
Losses and Special Payments	25/26	Y	Oct-22	06-Oct-25	
Stores & Stocks	25/26	Y	Oct-22	06-Oct-25	
Counter Fraud Bribery and Corruption Policy	25/26	Y	Oct-22	25-Nov-25	
Engaging Off Payroll Workers	25/26	Y	Feb-23	02-Feb-26	
Accounts Payable	25/26	Y	Feb-23	02-Feb-26	
Patients' Property	25/26	Y	Feb-23	02-Feb-26	
Purchasing Cards	25/26	Y	Feb-23	02-Feb-26	
General Ledger	26/27	Y	Apr-23	18-Apr-26	
Policy and Governance approach for Commissioning Additional (External & In sourced) Non NHS Clinical Services	26/27	Y	Apr-23	18-Apr-26	
Procurement Policy	26/27	Y	Sep-23	12-Sep-26	
Capital Procedures and Guidance Notes	26/27	Y	Nov-23	28-Nov-26	
Patients' Travel Costs Policy	26/27	Y	Nov-23	28-Nov-26	
Cash and Bank	26/27	Y	Nov-23	28-Nov-26	
Petty Cash	26/27	Y	Feb-24	08-Feb-27	
Petty Cash - Mental Health	26/27	Y	Feb-24	08-Feb-27	
Accounts Receivable	27/28	Y	Apr-24	16-Apr-27	
Counter Fraud Communication Strategy	27/28	Y	Apr-24	16-Apr-27	
Contract Management	27/28	Y	Apr-24	16-Apr-27	
Capital Assets and Charges	27/28	Y	Jul-24	09-Jul-27	



2. Technical Accounting Issues

Technical updates

There have been two technical accounting updates issued by Welsh Government since the April 2024.

Update note 1 covered the following areas.

- IFRS 17 Insurance contracts: application guidance – IFRS 17 sets out the principles for the recognition, measurement, presentation, and disclosure of insurance contracts within the scope of IFRS 17 and replaces the previous standard IFRS 4 Insurance Contracts. IFRS 17 significantly changes the accounting treatment of Insurance for insurance contracts, this will:
 - increase the transparency of entities' financial position and performance; and
 - make financial statements more comparable.

IFRS17 applies if there is an insurance contract under which one party (the issuer) accepts significant insurance risk from another party (the policyholder) by agreeing to compensate the policyholder if a specified uncertain future event (the insured event) adversely affects the policyholder.

The Health Board will be undertaking a review of all insurance contracts held to ascertain the following.

- Is there an agreement between 2 or more parties?
 - Is there a transfer of risk from the issuer of the contract to the policyholder? If so, is the transferred risk insurance risk and does it meet the definition of significant insurance risk under IFRS 17?
 - Does the contract cover nan uncertain insured event which, if occurred, would adversely affect the policyholder?
- Annual Data collection exercise re PFI/PF2 projects as at 31.03.2024.
 - 2023-24 Pensions Assurance Statement to be submitted by 31.05.2024.

Update Note 2 covered the following areas.

- IFRS 16 Property and Non-Property Lease return – request to provide budgetary information of the next three years 2025-26, 2026-27, 2027-28, as a result of the application of IFRS 16. Submission required by the 6th of September 2024.
- Month 6 Welsh Government Agreement of Balances exercise timetable – October 2024.
- S1 and S2 Templates – movement of assets within NHS Wales – templates to be reviewed and amended templates issued for completion and submission (where relevant) by 10th January 2025.



- NHS Wales Indices 2024-25 to 2028-29. District Valuer has been engaged to provide a report (expected mid-September) detailing the 2024-25 to 2028-29 indices for NHS Wales land and buildings. To be issued in a technical update when received.

4. Public Sector Payment Policy (PSPP)

The following table shows the Public Sector Payment Policy performance for the month of July 2024 and on a cumulative basis.

Category	Invoices	In Mth %	YTD %
NHS	Value Number	99.5 90.5	96.3 91.6
Non NHS	Value Number	96.9 97.9	96.3 97.4

The HB has achieved the target to pay 95% of the number of Non-NHS creditors within 30 days of delivery of goods/services in July and cumulatively.

There has been a slight increase in the number & Value of NHS invoices paid within 30 days this month and a significant improvement over last year when it was well below 90%. NHS invoices in breach of the 30-day payment for April – July are in the process of being reviewed with the relevant managers to be contacted to make them aware of the non-compliance with a request to take the appropriate action.

5. Payments in Excess of £100K

There were 3 exceptional payments made in the period between March and July 2024. All 3 of these payments were made in line with the Health Board's Approval Process and received the correct level of authorisation, including authorisation by Welsh Government, but due to their nature, should be highlighted.

Supplier	Payment Date	Payment Amount	Description
Abergavenny Facilities Ltd	26/06/24	£100,800	Settlement Payment for Llanwenarth Suite
Blake Morgan LLP	28/06/24	£5,430,000	Purchase of Chepstow Hospital Lead Lease
Lilyalex Properties Ltd	25/07/24	£350,000	Bargoed Hall Dilapidations Settlement Payment

There were no further exceptional issues to report.



6. Standing Financial Instructions

There is no further update on the standing financial instructions.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is requested to note the report and approve the updated procedures:

- Salary Sacrifice (Appendix 1)
- Out of Area Referrals to Secondary Care (Appendix 2)

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 3.5 Record Keeping Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Finance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol:

Further Information:

Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau:	FCP – Financial Control Procedure



Glossary of Terms:	CMA – Central Management Accounting IFRS – International Financial Reporting Standards PSPP – Public Sector Payment Policy NWSSP – NHS Wales Shared Services Partnership PAYE – Pay as You Earn HMRC – His Majesty's Revenue and Customs CCG – Clinical Commissioning Group ICB – Integrated Care Board PFI – Private Finance Initiative
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

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



<https://futuregenerations.wales/about-us/future-generations-act/>





Aneurin Bevan University Health Board

Salary Sacrifice Financial Control Procedure

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

Status: DRAFT
Approved by: Audit Committee
Owner: Director of Finance, Procurement &
Vale

Issue date: DRAFT
Review by date: DRAFT
Policy Number: ABUHB/Finance/0883

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1. Introduction

Aneurin Bevan University Health Board operates a number of salary sacrifice schemes for the benefit of its staff members.

To facilitate salary sacrifice schemes the Health Board will generally make payment to the supplier for goods and/or services and recover the costs from members of the scheme, over the course of the salary sacrifice agreement.

2. Policy Statement

Aneurin Bevan offers a range of salary sacrifice schemes to its employees allowing them to pay for goods and services directly through their salaries. Salary sacrifice works by reducing an individual's gross pay equal to the contribution made to the scheme and can result in a reduction in tax, pension and NI payments that can, subject to current legislation, sometimes offer financial benefit to individuals.

This procedure provides a framework to ensure effective financial controls are in place for:

- Setting up a new scheme
- Managing and renewing existing schemes,

The Health Board is committed to ensuring that it has sound financial controls in place; it is compliant with HMRC taxation and VAT regulations and also minimum wage regulations.

This procedure must be read in conjunction with the Salary Sacrifice Governance Framework which is attached in Appendix 1

3. Aims

The aims of the FCP are:

- To ensure that Aneurin Bevan University Health Board recovers all costs relating to the provision of a salary sacrifice scheme and they are properly accounted.
- To ensure contracts for salary sacrifice services are managed effectively.

- To ensure that HMRC rules regarding VAT and PAYE are considered and adhered to before entering into any salary sacrifice scheme
- To ensure compliance with minimum wage regulation.

This procedure should be read in conjunction with the appendices attached.

4. Scope

This document relates to all salary sacrifice schemes operated by Aneurin Bevan University Health Board including all current schemes, all renewals of existing schemes and all new salary sacrifice schemes.

The document relates to setting up, operating and managing all schemes.

This procedure must be read in conjunction with guidance relating to individual schemes. It must also be read in conjunction with the Health Boards [Standing Orders](#), [Standing Financial Instructions](#), [Recovery of Overpayments to Employees](#).

5. Roles and Responsibilities

5.1 Workforce & Organisational Development Director

The Director of Workforce & Organisational Development is responsible for identifying a Scheme Manager for each salary sacrifice scheme and for keeping a register of schemes.

5.2 Assistant Director of Finance (Financial Systems and Services)

The Assistant Director of Finance (Financial Systems and Services) is responsible for ensuring that:

- Each scheme is separately and properly accounted.
- Providing advice to the scheme manager with regard to the correct treatment of VAT and PAYE.
- Ensuring that schemes comply with HMRC requirements

- Ensuring that all monies relating to the scheme due to the Health Board are collected
- All payments relating to schemes are properly and promptly paid to suppliers and HMRC

5.3 Scheme Manager

The Scheme Manager will be responsible for ensuring that due diligence has been carried out prior to the set-up of a new scheme. That proper arrangements are in place to safeguard the Health Board against poor value or loss. Also, that proper governance arrangements are in place relating to the day to day management of the scheme.

6. Salary Sacrifice

6.1 Salary Sacrifice Schemes

The Director of Workforce & Organisational Development must ensure that a Scheme Manager is identified and is assigned responsibility for each salary sacrifice scheme operated by the Health Board. A register of all schemes must be kept by The Director of Workforce and Organisational Development and must hold the following details:

- The Scheme Manager
- The name of the supplier
- The duration of the contract (start and finish dates)
- The governance and reporting arrangements for the scheme
- The annual performance reports of each scheme
- A copy of the contract with the supplier

6.2 New Schemes

Before considering setting up a new salary sacrifice scheme, a Scheme Manager must be identified and should ideally be a senior manager from the related department. The Scheme Manager must ensure that a group covering all relevant parties (Workforce, Corporate Finance, Payroll, Procurement, Accounts Payable) is set up to manage the implementation of the scheme.

The Scheme Manager must ensure the following points are addressed by the group before implementing any new scheme:

- That the proposed scheme provides value for money for the Health Board and its staff members
- The correct procurement procedures have been followed including the relevant level of authorisation as per the [Scheme of Delegation](#)
- HMRC rules regarding VAT relating to the specific scheme are followed
- HMRC rules in relation to benefit in kind charges for Use of Asset and Transfer of Asset charges are clarified and confirmed.
- Scheme literature must clearly indicate what the tax implications of the scheme will be for staff.
- PAYE arrangements relating to individual salary sacrifice schemes are followed
- PAYE arrangements are in place for the reporting of benefit in kind charges through the P11D process where required
- Operational accounting arrangements are agreed.
- That there is a process for ensuring that individuals' basic pay does not drop below the minimum wage with the check undertaken by Payroll or a member of the Director of Workforce and Organisational Development team.
- That there is a process for notifying the Accounts Receivable department to enable them to recover any outstanding debt in a timely manner
- There are proper arrangements in place for recording and reconciliation of costs and deductions of the scheme
- The scheme proposal is agreed by the Executive Team.

6.3 Managing and Renewing Existing Salary Sacrifice Schemes

The Scheme Manager must ensure that robust governance arrangements are in place to manage the scheme.

As a minimum the Scheme Manager must set up a group to review the efficacy of the scheme. The group must be chaired by the Scheme Manager and should include members from:

- Workforce and Organisational Development

- Corporate Finance
- Payroll
- Procurement

The group must meet at least annually and report to the Director of Workforce & Organisational Development reviewing:

- The effectiveness of the operational arrangements that are set out above under section **6.2** for New Schemes
- Contract management review including contract reviews, timeframes for termination of scheme, members and notifications
- Monitoring the financial performance of the scheme and value for money review.
- Ensure proper arrangements are in place for the procurement and renewal of a scheme.
- Ensure the scheme renewal proposals are approved by the Executive Team.

7. Implementation

The procedure will apply to any existing and new salary sacrifice schemes.

8. Equality

An Equality impact Assessment has been completed.

9. Audit

The policy will be subject to internal audit review from time to time.

10. Review

The procedure will be reviewed every 3 years unless significant changes are required within that timeframe.

11. Appendix 1



Salary Sacrifice Governance Framework

Purpose

In April 2018 ABUHB agreed a Salary Sacrifice Financial Control Procedure with the purpose of providing a framework to ensure effective financial controls were in place to support the setting up of new schemes and managing new and existing schemes.

The procedure also endorses the establishment of robust governance arrangements in place to manage schemes.

The management of schemes is undertaken by:

- Workforce and OD
- Corporate Finance
- Payroll Department
- Procurement

The purpose of the Governance Framework is to ensure there are effective operational arrangements in place to support:

- The contract management and review of schemes and staff communications and notifications.
- Monitoring financial performance of the schemes and value for money
- Ensure proper arrangements are in place for the procurement and renewal of a scheme
- Ensure the scheme renewal proposals are approved by the executive team.

1. The contract management and review of schemes and staff communications and notifications

This ensures that roles and responsibilities are identified between functions, clear timescales and reporting and staff schemes have appropriate access and screening criteria.

1.1 Roles and responsibilities

A working group with all roles will support the operational arrangements of the respective salary sacrifice schemes. A Terms of Reference for this group has been developed (Appendix 3).

Role	Function
Budget Manager	- To approve or decline an application for the salary sacrifice car scheme, confirm employment status and this meets the eligibility of the scheme for the period of the scheme e.g. contract length. - The Manager must realise that when they are supporting the application for a salary sacrifice scheme, their employee will receive less money and they have a duty of care to protect staff from financial risks that may affect workforce wellbeing.
Scheme Manager	- The Scheme Manager will be required for each scheme within their responsibility for ensuring that due diligence has been carried out when setting up the scheme. - Ensure local governance is in place to ensure day to day management of the scheme and aligns to the key principles set out in the Salary Sacrifice Financial Control Procedure.
Workforce and OD	- Establishment of benefits schemes for staff through local intranet or benefits portal. - Administration of salary sacrifice working group meetings. - Ensure alignment with WOD policies and alignment with minimum wage, equality, wellbeing, inclusion on overall staff benefits for recruitment and retention information. - Management of employee relations and engagement with TU when setting up new schemes (with scheme manager). - General information to staff in relation to ABUHB approval process in conjunction group.
Corporate	Reconciliation of the existing schemes on a monthly

Finance	basis ensuring deductions are being correctly made via payroll; VAT is being treated correctly and that Employers savings are being reflected against the correct salary sacrifice cost centre. • Involved in the evaluation of all proposed new schemes. • Provide recommendation and guidance in relation to HMRC rules and changes including VAT, Asset and Transfer charges. • PAYE arrangements, in place for the reporting of benefit in kind changes through the P11D process. • Management of operational accounting arrangements
Payroll	• Ensure there is a process for notification to the Accounts Receivable department to enable them to recover any outstanding debt in a timely manner. • PAYE arrangements, create the calculation and reconciliation.
Deductions from salary	• Cycle to Work – this will be either Payroll Services or Shared Services depending on who holds the responsibility for administration of the scheme in the future. • Fleet Solutions - Shared Services • Home technology – Shared Services • Pensions – Shared Services <u>*Please note:</u> This relates to the option for employees to seek pension advice, which can be paid via salary. It is <u>not</u> in relation to where employees can pay more into their pension which only applies to private pensions

2) Monitoring financial performance of the schemes.

Corporate Finance will be responsible for setting up a new cost centre for all new salary sacrifice schemes. Corporate Finance will also be responsible for reconciling the schemes on a monthly basis and confirming the Employers Health Board savings achieved from the implementation of the scheme. The Employers savings will be

moved to the salary sacrifice cost centre on a monthly basis and reflected within the divisional monthly reported position.

3) Ensure proper arrangements are in place for the procurement and renewal of a scheme

Each Scheme Manager will be responsible for the monitoring of contract reviews, timeframes and notification to the group of issues or concerns.

Proposals for new schemes will require full business justification in terms of value, benefits and outcomes supported by the Salary Sacrifice Group prior to executive approval.

Meetings to be held quarterly or may be arranged to review particular schemes.

12. Appendix 2

Staff guidance when applying for a Salary Sacrifice scheme



Salary%20sacrifice%
20guidance%20to%

13. Appendix 3

Staff factsheet in relation to potential pension implications if undertaking a scheme

It is advisable to seek independent pension advice for further information.



Salary Sacrifice
Factsheet NHS...

14. Appendix 4

Terms of Reference of the Salary Sacrifice Group



Salary sacrifice
Terms of Refe...



Aneurin Bevan University Health Board

Out of Area Referrals to Secondary Care

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.

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1 Executive Summary

The procedure for Out of Area Referrals to Secondary Care outlines Aneurin Bevan University Health Board's approach for providing and commissioning secondary care services for the residents of Newport, Torfaen, Monmouthshire, Caerphilly and Blaenau Gwent (Gwent Residents) and English residents registered with a Welsh GP (Cross Border Residents). This procedure is aligned to the following key organisational and Welsh Government Plans including:

- Well-being of Future Generations (Wales) Act 2015.
- Social Services and Wellbeing (Wales) Act 2014.
- Aneurin Bevan University Health Board Integrated Medium Term Plan.
- Aneurin Bevan University Health Board Clinical Futures Strategy.
- NHS Act 2006 (as amended by the Health and Social Care Act 2012),

The procedure ensures the organisation has a systematic and planned system in place to:

- Plan and secure secondary care services in line with the Welsh Government and Health Board's strategic aim of providing safe, high quality, sustainable services as locally as possible.
- Make appropriate arrangements for the determination of the provision of care to meet the identified needs of any individual patient whose routine secondary care treatment may be better served by a hospital outside the Health Board's direct provision; including where commissioned services require prior approval, generally with English providers.
- This procedure has been developed to enable the Health Board to make clear decision-making regarding **where** an individual patient receives their treatment. This procedure does not determine what treatment will be made available. A separate process exists for decisions about treatment under the Individual Patient Treatment Request Process.

Exceptions to this procedure include temporary arrangements intended to alleviate pressures within Health Board services as agreed by the Executive Team. Details of current temporary arrangements are included in Appendix 5.

2. Background and Purpose

2.1 Aneurin Bevan University Health Board has a statutory responsibility to commission and provide healthcare that meets the needs of its local population in accordance with the NHS (Wales) Act 2006 and The Local Health Boards (Establishment and Dissolution) (Wales) Order 2009 and associated Regulations.

The Health Board is also funded to provide healthcare for English resident patients who are registered with a Welsh GP although the commissioning responsibility for English resident patients is stated in the Health and Social Care Act 2012 as being with the relevant Integrated Care Board (ICB). It achieves this either by directly providing the healthcare or by commissioning healthcare from other service providers.

2.2 Significant resources are invested in commissioning secondary care services outside the Health Board for the registered population of Gwent. Secondary care refers to community or acute healthcare and can either be elective or emergency care. This procedure refers to elective care, which is planned specialist medical or surgical care (predominantly acute services), usually following referral from a primary or community health professional, such as a GP.

2.3 Delivering these services requires a strategic planning framework as part of the Health Board's IMTP. As part of the wider work programme, an IMTP framework has been developed which reflects the key processes and planning cycle that the Health Board has adopted to support the delivery of its core aims and objectives for healthcare for Gwent residents and Cross Border residents.

The Health Board's IMTP and Clinical Futures Strategy articulate plans to:

- **Deliver Patient Centred Services:** taking all opportunities to organise services around the citizen and balancing our whole system of care.
- **Focus on Safety, Excellence and Quality:** we have a responsibility to ensure that patients and the population we serve receive the best quality, evidence-based care we can provide and to ensure we deliver the basics exceptionally

well. We also have a responsibility to consider quality in its wider definition including patient experience (and appropriate access), maximum productivity and minimal waste; as well as clinical effectiveness and patient safety.

- **Achieve better use of resources:** whatever changes we make and wherever we deliver care we must do this in line with best practice, with an excellent workforce, within the resources we receive and with confidence that improvements can be maintained.

The Health Board continues to adopt a collaborative approach to commissioning, developing partnerships with neighbouring Health Boards, Local Authorities, Third Sector partners, the Integrated Care Boards and others as necessary to ensure the needs of the population are met.

2.4 This procedure has been developed to provide an overview of the Health Board's planning and commissioning principles and processes for elective services in secondary care. The policy aims to ensure the Health Board utilises its finite resources as effectively as possible.

2.5 This procedure is in line with developments within other border LHBs in Wales with similar aims of strengthening the sustainability and equity of access in local services.

3. Aims and Principles

- The Health Board aims to establish simple uniform arrangements based around high quality, sustainable, local services for Gwent resident patients.
- This will be delivered by ensuring the Health Board is the primary provider of secondary care services for Gwent residents. This will help support the Health Board's aim of working with residents that fall within its catchment area, partners and clinicians to invest in local, high quality and sustainable services.
- Where this cannot be provided by the Health Board's own services for reasons such as resources, expertise or capacity, then the Health Board will look to plan and secure the necessary services with other NHS Providers in Wales, through its agreed care pathways. Where the services cannot be provided by the Health Board or with other Welsh

providers, the Health Board will plan and secure services from other appropriate providers.

The overarching strategy of the Health Board is to:-

- Deliver local services for local residents within the finite resources available whilst maintaining equity of access. This should be considered the default option for Gwent residents.
- Enable Cross Border patients to exercise their right to choice of secondary care provider either in England or within the Health Board. This is enacted through the Referral Assessment Service (RAS) as described in section 5.
- Enable Gwent residents to appropriately access services not offered within the Health Board at English providers or in other home countries.

A diagram is outlined in Appendix 1 showing the referral pathway

Cases where the clinical presentation of the patient means that they would be likely to gain a significant clinical benefit from the treatment, more than other patients with the same condition at the same stage, and that the value for money of the intervention, for that particular patient is likely to be reasonable, applications will be considered through the Individual Patient Treatment Process.

4. Scope

4.1 Inclusions

This procedure applies to

- The resident population within the geographical catchment area of the Health Board, to whom it has a statutory responsibility for arranging services as outlined in the Local Health Board (Directed Functions)(Wales) Regulations 2009 (Gwent patients).
- Cross Border Patients, as defined by the NHS Act 2006 (as amended by the Health and Social Care Act 2012) and the Protocol for Cross Border Healthcare Services (April 2013). (English resident patients with a Welsh GP)

- Secondary care referrals, only made by General Practitioners and Consultants with referral rights within and outside the Health Board's area.

4.2 Urgent Suspected Cancer Referrals

Referrals for urgent suspected cancer must be referred using e-referral where the patient has chosen to be referred into the Aneurin Bevan University Health Board respective tumour sites which has been set up in accordance with NICE guidelines. If a Cross Border patient has requested to be referred to a local hospital in Gloucester, Hereford or Bristol then the referral will be made by email.

4.3 Exclusions

4.3.1. This procedure does not apply to the following services:

- Emergency Treatment, (following national agreement to reimburse providers for emergency treatment, excludes A&E attendances specifically as a reciprocal agreement between NHS Wales and NHS England exists).
- Those provided as a result of Individual Patient Requests (IPTR).
- Community based services such as district nursing.
- Mental Health and Learning Disabilities.
- Requests for treatment in countries of the European Economic Area.
- Looked after children.
- The specialised services pathways established as part of the arrangements under the NHS Wales Joint Commissioning Committee(Wales) Regulations 2009.

4.3.2. This procedure does not apply to the following cohorts of patients:

- Patients diagnosed with HIV/ AIDS as outlined in the Welsh Government's Document 'Providing for the needs of people with HIV/AIDS in Wales: National Care Pathways and Service Specification for Testing, Diagnosis, treatment and Supportive Care.

- Veterans as prescribed by the Welsh Government's WHC (2017) 41 Armed Forces Covenant and Healthcare Policy for Veterans.

5. Cross Border Healthcare Arrangements

Changes to English NHS legislation which came into effect from 1 April 2013 mean that consultant-led care for English residents is the responsibility of their Integrated Care Board (ICB), even if those patients are registered with a GP practice in Wales. In 2015 a Referral Assessment Service (RAS) was established enabling English patients to have their right to choice; and appropriately manage English-resident patient referrals into English-commissioned services or back into the Welsh NHS if that was their patient choice.

Welsh GPs are under no contractual obligation to use the RAS and some may choose not to participate. Should a Monmouthshire GP choose not to participate in the RAS now or in the future then their registered patients will be treated in the same way as other English residents

5.1 The Referral Assessment Service

The Referral Assessment Service (RAS) is intended to receive referrals to secondary care from Welsh GPs. The RAS only covers English-resident patients wishing to access care commissioned by their ICB for first appointment, outpatient consultant-led care.

5.2 The functions of the RAS are to:

- Accept electronic patient referrals from Welsh GP practices;
- Use a case management approach to accept and assess agreed referrals for secondary care from Welsh GP practices;
- Liaise directly with patients and Welsh GP practices about patient care needs and choice, as necessary; and
- Refer patients to the appropriate provider.

6. Provision of services outside these arrangements

6.1 The Health Board recognises that there may be occasions where a patient's secondary care treatment may be better served by an alternative NHS provision outside the

arrangements outlined in Section 3 of this procedure.. In such cases, the needs of each patient will be assessed and determined on a case by case basis at the discretion of a relevant senior clinician.

A case will be considered where the referring clinician reaches a judgement that there are circumstances which, if unaddressed, are likely to have a serious impact on the patient's continuing health and wellbeing. This may include a requirement to access a service outside of the ABUHB existing arrangements to meet the Patient's needs.

6.2 In reaching a decision, the Health Board will work to the following ethical framework:

- Take into account and weigh all the relevant information as to the circumstances provided by the referring clinician;
- Give proper consideration to the views of the patient, GP or referring clinician, whilst being mindful of the need to make the best and fairest use of NHS resources in Gwent;
- Take into account the cross border protocol and RAS process;
- Take into account all material factors;
- Act in the utmost good faith;
- Adhere to the requirements of the Health Board's Equality and Diversity Policy.
- Consider the consequences of Welsh Government's patient choice rules.

7. Process for requesting an external referral outside these arrangements.

7.1 Any referrals to services outside the Health Board's current arrangements must be supported by a written referral on the Health Board's Out of Area Referral Form, sent by email to the Health Board's Prior Approval Team. The relevant form and contact email details are outlined in Appendix 2.

7.2 Referrals will only be accepted from the following:

- General Practitioners within the catchment area of Aneurin Bevan University Health Board;

- Consultants working within or outside of Aneurin Bevan University Health Board;

Please note:

- Referrals directly from the patient or from a third party (e.g. elected politicians, relatives) will be returned with the advice that the case should be discussed with a clinician (usually the patient's GP).

7.3 All referrals must be supported with all relevant appropriate evidence to help inform the decision making. Where this is not provided, further information may be requested from the GP or referrer.

7.4 Subject to the provision of all relevant appropriate information, the referral will be reviewed by the Clinical Director or his/her nominated person whose expertise is relevant to the service requested and the decision will be communicated to the referrer within three working days of receipt of the referral. If the referral is from the Clinical Director the Out of Area Team will assume it is clinically appropriate.

7.5 If additional information is received after the original decision was taken that may have impacted on the decision an updated opinion may be sought.

8. Application for review following a negative decision

8.1 If a patient or their referring clinician considers that a review of the decision is warranted, a review can be requested in writing by the patient to the Review Panel at:

The Commissioning Team
Finance Commissioning & Contracting
Room 106
Headquarters
St Cadoc's Hospital
Lodge Road
Caerleon
Newport
NP18 3XQ

Tel 01633 623994

8.2 The panel should comprise;

- Non Officer Member (Chair)
- Consultant in Public Health
- General Practitioner
- Senior Clinical Representative e.g. Assistant Medical Director/ Clinical Director.
- ABHB Senior Management Representative

Additional advice can be co-opted for assistance where a particular request requires clinical / professional advice. The panel will be quorate if 3 of the 5 members are present, attendees must include the Non Officer Member (Chair).

All requests for review will need to be made by e-mailing the appropriate review form as outlined in Appendix 3 to the Prior Approval Team within 28 working days from the date of despatch of the letter detailing the decision. All requests must be specific in detailing the grounds for which the review is being made. An acknowledgement letter will be sent within three working days. The process for a Review of Decision is provided at Appendix 4.

The Review Panel will meet within 28 working days (subject to the availability of the Non Officer Member) of receipt of the request to consider the review in the context of evidence presented.

Following the review, a decision letter will be issued. The decision letter will not only state the decision but will also set out the reason(s) for the decision. There is no further right of appeal.

9. Clinical Governance

9.1 Confidentiality and Information Security

In operating this procedure, the Health Board will have due regard to the need to ensure that patient confidentiality is maintained at all times and that the Health Board complies with the requirements of the Data Protection Act 2018 and Caldicott Principles of Good Practice.

- 9.2** The Out of Area Team will rely on the relevant Clinical Director to ensure that the referral is clinically appropriate. Reliance will also be placed on his/her opinion of whether the treatment can be undertaken internally or through existing arrangements.

10. Monitoring

- 10.1** The Health Board will monitor the impact and application of the procedure through a range of mechanisms including:

- External referral rates and its associated financial flows at a specialty level
- Audit of requests for external referrals and any associated requests for review to ensure the Health Board's decision making is consistent, fair and equitable.

- 10.2** This procedure will be formally reviewed by the Health Board every three years or more frequently depending on experience and outcome of its application.

11. Responsibilities

The Director of Finance, Performance and Value is responsible for the procedure and its implementation.

12. Further Information

Further information can be obtained from the Director of Finance, Procurement and Value .

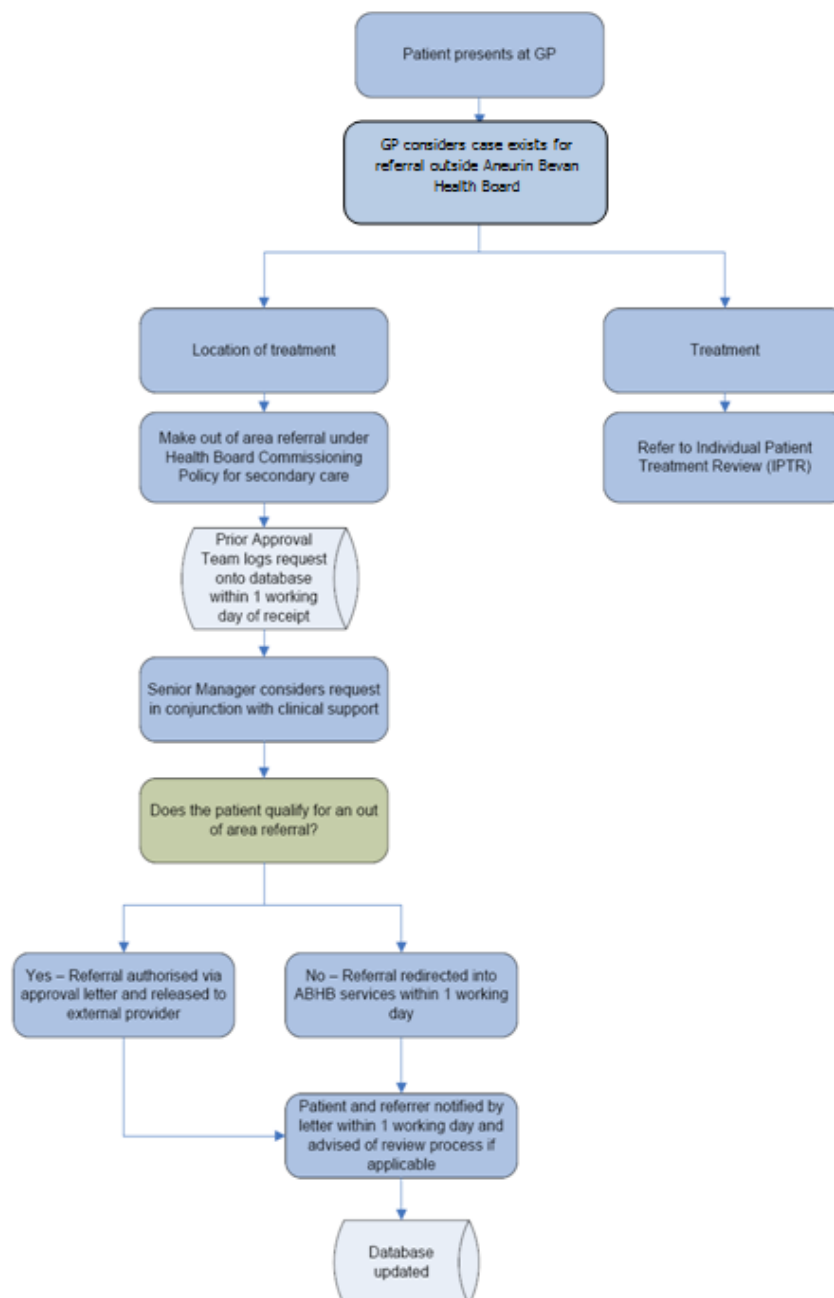
13. Appendices

- Appendix 1: Diagram showing the referral pathway based on the Health Board's planning and commissioning principles for secondary care
- Appendix 2: External Referral Request Form and standard operating procedure.
- Appendix 3: Review of Decision Form and standard operating procedure.
- Appendix 4: Diagram showing process for Review of Decision
- Appendix 5: Temporary Exclusions to alleviate pressure in Health Board services

Appendix 6: Out of Area Referrals to Secondary Care Review Panel Terms of Reference

This policy has undergone an equality impact assessment screening process using the toolkit designed by the NHS Centre Equality & Human Rights. Details of the screening process for this policy are available from the policy owner.

Appendix 1 - Aneurin Bevan Health Board Out of Area Referral Policy



Note : Consultant referrals into the Out of Area process should be signed by the relevant clinical director and will enter the process at the 'Prior Approval Team logs request onto database within 1 working day of receipt' step as outlined in Appendix 1.



Appendix 2

Aneurin Bevan University Health Board **Out of Area Referral Request Template** **(THIS TEMPLATE WILL CONSTITUTE A REFERRAL)**

Please indicate referral destination:

Preferred hospital (if known):

Patient Demographics			
Full Name:		Address:	
Other Names:			
Sex:			
Date of Birth:		Preferred Phone No.:	
NHS Number:		Home Phone No.:	
Hospital Number:		Work Phone No.:	
Is a translator required?	Yes ☐ No ☐	Mobile Phone No.:	
Email Address:			

Practice Details			
Referring GP:			
Registered GP:			
GMC Code:			
Practice Name:			
Practice Code:		LHB Code:	
Practice Address:			
Tel No:		Fax No:	

Consultant Details	
Referring Consultant:	
GMC Code:	
Health Board:	
Directorate:	
Tel No:	

Other referring clinician	
Contact Address/Details	

Referral Details	
Specialty:	
Reason for referral/ condition specific information: (Please provide all information you would ordinarily include in a referral letter)	
Please provide details relating to why the patient falls outside the Health Board’s arrangements for out of area referrals. It is essential that the reasons are clearly stated and supporting information is provided. Please refer to Section 5.1 of the Policy for Out of Area Referrals	

Investigations Undertaken: (Please include date and hospital for every investigation)	
Significant Medical & Social History (inc. Mental Health) <i>Please attach list if possible</i>	
Repeat Medication <i>Please attach list if possible</i>	

Additional Comments:	

Referring Doctor (Print Name):	Signature:	Date:

Please return completed templates by email to the Prior Approval Team, email address is ABB_Prior.ApprovalTeam@wales.nhs.uk

FOR INTERNAL USE ONLY	
DATE REFERRAL RECEIVED	

FOR INTERNAL USE ONLY	
HEALTH BOARD DECISION	AUTHORISATION STAMP
REFERRAL AUTHORISED FOR RELEASE TO REQUESTED HOSPITAL REFERRAL TO BE REDIRECTED INTO ABHB OR ALTERNATIVE NHS SERVICES IN WALES (delete as appropriate)	



Appendix 3
Aneurin Bevan University Health Board
Application for Review of Decision for Out of Area Referral
request

Name and Contact Details of Clinician or Health Professional requesting the review
Please provide contact details of the patient
Details of Referral

Please provide details on what grounds the request for a review is being made.

If available, please provide additional information (additional to the information already submitted as part of the original out of area referral request) to support the review stating clearly how the Health Board's decision to not refer the patient out of area constitutes as having a very serious impact on the patient's continuing health and wellbeing as outlined in Section 5.1 of Out of Area Referral Policy.

Additional Comments:

Referring Clinician (Print Name):	Signature:	Date:

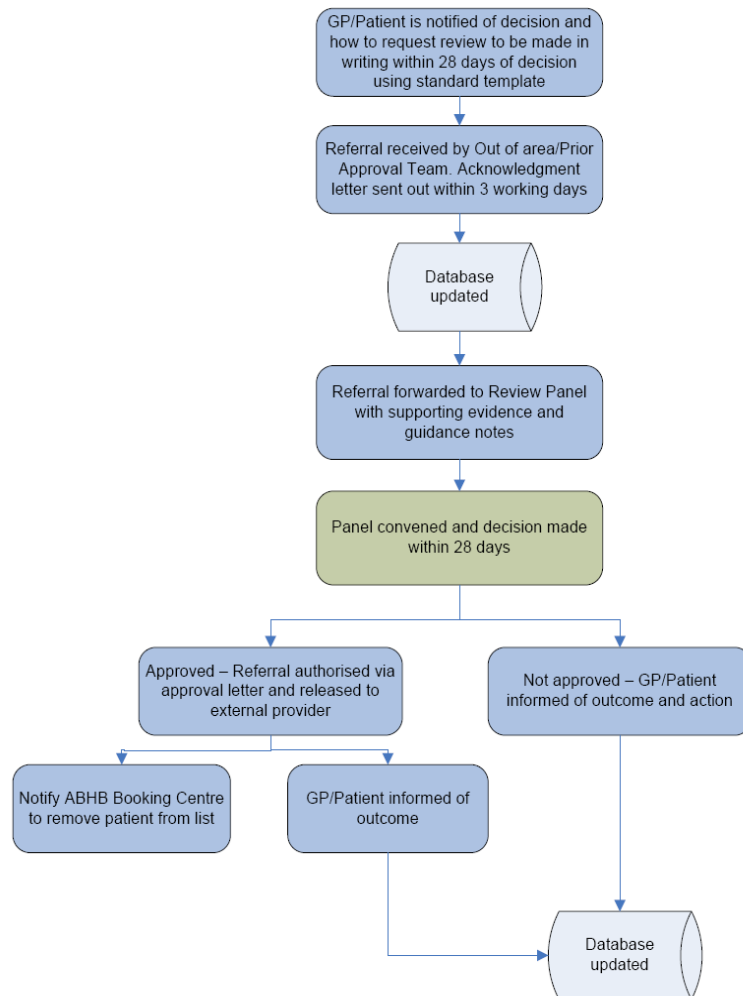
In accordance with the Out of Area Referral Policy, the review must be requested within 28 working days of being notified of the decision by the Health Board not to refer. The request for review must be sent using the dedicated email address to the Prior Approval Team. The email address is ABB_Prior.ApprovalTeam@wales.nhs.uk

Following receipt of the request for review, the Health Board will convene a panel and make a decision within 28 working days of receiving the request for a review.

FOR INTERNAL USE ONLY	
DATE REVIEW RECEIVED	

FOR INTERNAL USE ONLY	
HEALTH BOARD DECISION	AUTHORISATION STAMP

Appendix 4 - Aneurin Bevan Health Board Out of Area Referral Review of Decision Policy



Appendix 5: Temporary Exclusions to alleviate pressure in Health Board services.

Gwent residents are currently able to access the following specialties at University Hospital Bristol & Weston NHS Foundation Trust without prior approval:-

- Trauma and Orthopaedics
- Ophthalmology
- Oral Surgery
- Haematology
- Oncology

Appendix 6: Out of Area Referrals to Secondary Care Review Panel

Terms of Reference

1. Constitution

This panel has been established as part of the Policy for Out of Area Referrals to Secondary Care. The outcomes of the panel will be reported to the Board as part of the existing reporting arrangements of Aneurin Bevan Health Board's Commissioning Board. The panel has no executive powers other than those specifically delegated in these Terms of Reference.

2. Membership

The panel membership shall comprise of:

- Non Officer Member (Chair)
- Consultant in Public Health
- General Practitioner
- Senior Clinical Representative e.g., Assistant Medical Director/ Clinical Director.
- ABHB Senior Management Representative

Additional advice can be co-opted for assistance where a particular request requires clinical / professional advice.

3. Quorum

The panel will be quorate if 3 of the 5 members are present, attendees must include the Non Officer Member (Chair).

4. Attendance

Commissioning Department representation will be present to provide advice on the national and ABHB policy matters.

The Review Panel will be supported administratively by the Commissioning Manager responsible for co-ordinating the Policy for Out of Area Referrals to Secondary Care.

5. Frequency

The Review Panel will convene and make decisions within 28 working days of the request for a review.

6. Authority

The Review Panel is authorised by the Health Board to hear requests for review of any decisions made by the Prior Approvals Team that support the Policy for Out of Area Referrals for Secondary Care and to uphold or reject the decision under review.

7. Duties:

The duties of the Review Panel include:

- To hear reviews against the Health Board's Prior Approval Team decisions and determine whether to uphold or reject the decision made.
- To consider new evidence presented on behalf of the patient by the referrer/clinical representatives.
- To make recommendations on actions in relation to the individual request required following the outcome of the review.
- To notify patient's and referrer(s) of the outcome of their review.
- To make recommendations on future processes within the Out of Area Referral Policy.

Exclusion: This panel cannot make clinical recommendations on individual patient requests for Out of Area Referrals

8. Reporting and Recording of Decisions

The minutes of the panel shall be formally recorded and be signed off by the Review Panel Chair.



Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	12 September 2024
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Clinical Audit Activity mid-year review 2024
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Dr James Calvert, Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Leeanne Lewis, Assistant Director for Quality & Patient Safety Joanne Stimpson, Quality and Patient Safety Lead for National Clinical Audit

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

Aneurin Bevan University Health Board is committed to delivering safe and effective care to the population of Gwent. Clinical Audit is an essential tool to ensure services are providing guideline defined standards of care. Where opportunities for improvement are identified through audit these are incorporated into SMART action plans for review by divisional and directorate leadership teams before sign off by the Clinical Effectiveness Group. Results of National Audit are discussed as a standing agenda item at PQSOC.

The National Clinical Audit Outcome Review Programme (NCAORP) is a set of audits mandated nationally. Participation provides the opportunity to benchmark our services against other UK health care providers.



Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

The Health Board strictly adheres to the NCAORP publication dates and ensures that there is communication between the Clinical Audit Team and the Clinical Leads for each audit to ensure audit participation and production of timely action plans.

Results of audit are one part of the ABUHB quality information system which can be triangulated with other sources of information such as complaints, incidents and patient experience to identify and reinforce good practice and to identify areas for improvement.

The Health Board uses an audit management system, AMaT (Audit Management and Tracking) to track recommendations from audits, record levels of service assurance, risk levels and to act as a repository for storing and checking completion of SMART action plans.

Cefndir / Background

The National Clinical Audit and Outcome Review Plan (NCAORP) published by the Welsh Government (WG) annually is one of the cornerstones in driving quality and safety of healthcare across Wales. It sets out in detail how findings from national clinical audit projects and outcome reviews are to be used to measure the quality and effectiveness of healthcare provided to patients and to assess year on year improvements. The plan details the full list of national audit projects that all healthcare organisations must fully participate in, where those services are provided. The Health Board's audit plan is based on NCAORP.

Following the Internal Audit report and recommendations in November 2022, the focus for the Clinical Audit Team has been to implement the Health Board's Clinical Audit Strategy. There has been engagement with Divisions and work has been undertaken to make the clinical audit process more effective. This has included producing standardised audit report templates to ensure more consistent reporting and improved scrutiny of action plans.

Implementation of the web-based Audit Management and Tracking system (AMaT) has helped facilitate tracking of audit results and the development of action plans.

Local audit plans, to supplement NCAORP Audits, have been developed by Directorates and are also recorded in AMaT. AMaT has been used to build audit proformas, capture data, produce results and develop SMART action plans, all within the same platform. This has allowed many of the recommendations within the internal audit report to be met.

There is a robust structure underpinning the reporting of Clinical Audit, with Executive Leadership delegated to the Medical Director. Assurance is provided by reporting to the Patient Quality and Safety Outcomes Committee (PQSOC), providing scrutiny of National Clinical Audit performance with robust development and monitoring of improvement plans.



Clinical audit is an important component of our commitment over the next three years to enable delivery of the Duty of Quality, as mapped to the Health and Care Quality Standards. This will support the delivery of a sustainable and resilient health and care system.

Asesiad / Assessment

The Health Board's Annual Clinical Audit Plan for 2024/25 and Clinical Audit Activity report for 2023/24 was ratified by Patient Quality and Safety Outcomes Committee (PQSOC) in April 2024.

There is a well-defined process for the scrutiny of National Clinical Audit Reports, which are presented to the Clinical Standards and Effectiveness Group (CSEG) following publication. Clinical Lead(s) for the service(s) are informed of the report due date on publication.

The Quality and Patient Safety (QPS) clinical audit team register the audit in the Clinical Audit Area via the web-based Audit Management and Tracking system (AMaT). The relevant documentation is provided to Clinical Leads, who provide CSEG with an analysis of local performance benchmarked against national recommendations. They then provide a "SMART" improvement plan for the Health Board which is available in AMaT, allowing completion deadlines to be tracked. Reports discussed at CSEG from April to July 2024 have been presented to PQSOC and can be found in the attached progress report.

The nine-month publication schedule for the NCACORP – covering the National Clinical Audit (NCA) programme and also the Clinical Outcome Review Programmes (CORP) has been shared with Directorates. The dates align with presentation of results at Clinical Standards and Effective Group (CSEG). A newsletter has been produced for Divisions to improve communication, sharing audit results and the plan for upcoming audits.

The annual audit plan will continue to ensure mandatory participation in all national clinical audits and national confidential enquiries, including participation in audits on the National Clinical Audit and Patient Outcomes Programme (NCAPOP).

AMaT is also utilised to record compliance with NICE guidance and HTW adoption, which can be used for clinical audit.

Once National Clinical Audits (NCA) are published on the Healthcare Quality Improvement Partnership (HQIP) webpage, they form part of our annual audit plan.

Participation in these audits has been reviewed and the team are ensuring these are discussed at CSEG. For 2024/25, for audits discussed at other Groups or Boards (e.g. Stroke, End of Life Care Board) will be invited to present at CSEG and ensure the recommendations and SMART actions are added to AMaT.



The Audit Management and Tracking (AMaT) programme is being widely used across the Health Board for conducting and reporting on local audits, as specified in the audit plan. The volume of audits being undertaken and the number of action plans being allocated is rising. This is demonstrated in the attached report.

As part of the implementation of the Clinical Audit Strategy; directorate and clinical leads are being asked to confirm their list of audits and identify any other projects that relate to clinical priorities where audit work will support the improvement of patient care. This includes audits that are required from clinical incidents, complaints or risks.

The audit team will continue to work collaboratively with Divisions, clinicians, service managers, divisional governance and quality managers as well as clinical staff to ensure that the clinical audit programme for their directorate meets all clinical, statutory, regulatory, commissioning and other Health Board requirements. Ongoing training to use AMaT will ensure healthcare professionals are enabled to participate in clinical audit in order to satisfy the demands of their relevant professional bodies (for example, for revalidation and professional development).

The clinical audit team are developing organisational and governance structures within AMaT to support full engagement in audits. This includes an escalation process to ensure the executive board is made aware when issues around participation, improvement and risk identification against recommendation are identified.

The internal audit report in November 2022 also made reference to the resource at operational level to ensure clinical audit is carried out to a high standard. As part of the ongoing programme of work a resource mapping exercise will be carried out to look at the current resource for data acquisition to participate effectively in the NCACORP. This will also include the resource to maintain the infrastructure of clinical audit.

A further key area of improvement going forward will be to ensure the results of all clinical audits undertaken are triangulated and inform future planning. The next audit activity report by the clinical audit team will review how the learning from clinical audit can be fed back to clinical areas.

Argymhelliad / Recommendation

Note the assurance provided by the clinical audit team in developing an ongoing clinical audit programme. A clinical audit activity report is being updated annually.



Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3. Effective Care 3.1 Safe and Clinically Effective Care 3.3 Quality Improvement, Research and Innovation Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termiau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau)



Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.



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University Health Board

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

MID-YEAR CLINICAL AUDIT ACTIVITY REPORT 2024/2025

**In conjunction with the
Clinical Audit Plan 2024/2025**

Introduction

Welcome to the Aneurin Bevan University Health Board Clinical Audit five month (April to August) Activity Report 2024/2025. This report will provide an update on activity for the year so far and look at current successes and challenges.

What we have accomplished so far...

As part of the mandatory participation in the Welsh National Clinical Audit and Outcomes Review Plan (NCAORP) the Clinical Standards and Effectiveness Group (CSEG) meet bi-monthly to discuss the findings from the national reports published in the first half of the year. The Audit results and actions are presented to CSEG, meetings are arranged in the following months:

May	July
September	November
January	March

The Health Board process has been aligned align to the Health and Care Quality Standards, as stipulated the Duty of Quality to provide high quality, safe and compassionate care.



Progress against 2024/25 Objectives

Key objectives for 2024/2025 – Apr 2024 - Aug 2024

➤ Work with Divisions to develop local audit plans.	➤ Local audits have been commenced, eg audits of NG Tubes & thromboprophylaxis for VTE
➤ Embed AMaT and run additional training sessions and raise audit awareness.	➤ Usage of AMaT continues to grow and training provided to staff
➤ Develop governance and reporting structure within AMaT.	➤ Governance and reporting structures are developing and improving with progression
➤ Work on process for tracking audit results; ensuring actions are formulated and completed on time and findings from national and local clinical audits are monitored and are utilised to inform future organisation learning and planning in the Health Board.	➤ Actions plans are being monitored at Corporate level and Ward level
➤ Review mechanisms to triangulate the learning from clinical audits and other sources of information to improve services.	➤ Through CSEG mechanisms are regularly reviewed
➤ Work collaboratively with the value based healthcare team to review impact of measures that compliment audit and benchmarking results.	➤ Ongoing work to look at joining work with the team
➤ Work with patient experience and involvement team to review how CIVICA and patient experience data can strengthen audit data.	➤ Consideration of how to triangulate data and progress
➤ Review our quality and safety structures and resource within the audit team and understand gap analysis for effective participation in Clinical Audit.	➤ The QPS team are continuously working with colleagues across the Health Board to ensure full participation in the NCAOPR

Achievements aligned to the Clinical Audit Plan 2024/25

Clinical Audit Plan 2024/2025 - Priority One

- All National Clinical Audits (NCA) are sighted by the Divisional Triumvirate and the Clinical Lead in a timely manner after publication via HQIP
- All Audits are presented to the Clinical standards and Effectiveness Group and furthermore to the Patient Quality and Safety Outcomes Committee (PQSOC)

Clinical Audit Plan 2024/2025 - Priority Two

- Divisions, Directorates and specialty level ward audits are being undertaken and actions are being worked on continuously (see slide 21) for AMaT action results.
- The usage of AMaT for audit is growing across the Health Board to ensure full participation.

Clinical Audit Plan 2024/2025 - Priority Three

- All Health Board staff are encouraged to utilise AMaT to quality improvement and support clinical governance.

Clinical Audit Plan 2024/2025 - Priority Four

- Groups and Committees across all disciplines within Aneurin Bevan University Health Board have registered audits using AMaT to support effective assurance processes.

All these achievements are aligned to the Clinical Audit Strategy

Aligned to Priority One in the Clinical Audit Strategy - There is scrutiny of national clinical audit performance with robust development and monitoring of improvement plans

- All National Audit Reports will be reviewed by Divisions, Clinical Directors and Clinical Audit Leads
- Divisions will work with Clinical Directors to develop an action plan where improvements are identified following audit
- The Division will support presentation of National Audit results and improvement plans at the Clinical Standards and Effectiveness group within two months of the audit publication date
- There will be ongoing monitoring of the improvement plan by the Division
- The National Audit results and improvements will be included in the Annual Clinical Audit Activity Report
- The outcome of the improvement plan will be included in the presentation to Clinical Standards and Effectiveness Group the following year, following publication of the next annual report
- Overdue actions are now being tracked and escalated to Directorate Managers and onwards to Divisional Triumvirates



Clinical Standards and Effectiveness Group – May 2024

Audit Name:	Report Title:	Clinical Lead:
NLCA - National Lung Cancer Audit	National Lung Cancer Audit State of the Nation report (01/01-31/12/2022 data; Eng & Wales)	Dr Mat Jones - Consultant in Medicine
FFFAP - Falls & Fragility Fracture Audit	Fracture Liaison Service Database (FLS-DB) Annual report - Improved FLS identification with gaps in monitoring: a call to action for national and regional planners	Dr Inder Singh - Consultant in Care of the Elderly
GICAP-NOGCA – National Gastrointestinal Cancer Audit Programme	National Oesophago-Gastric Cancer Audit (NOGCA) – State of the Nation Report	Tamsin Boyce - Consultant Surgeon
NAD - National Audit of Dementia	National Audit of Dementia (NAD) - Care in General Hospitals 2022-2023 Round 5 Audit Report	Dr Inder Singh - Consultant in Care of the Elderly

Audit Name:	Report Title:	CSEG Date:	Clinical Lead:
NLCA - National Lung Cancer Audit	National Lung Cancer Audit State of the Nation report (01/01-31/12/2022 data; Eng & Wales)	May 2024	Dr Mat Jones - Consultant in Medicine
Successes:		Concerns:	
The introduction of physician of the week, which allows us to prioritise the management of patients with lung cancer with one clinician from the respiratory team being the lead each week with dedicated time in their job plan, which has worked well and ensures that there is a consistent priority for patients with lung cancer within our service which it's ever expanding.		Below target treatment rates for surgical resection in NSCLC, SCLC chemotherapy and NSCLC advanced stage good PS treated with SACT (but all improved from 2021). Concerning numbers presenting as emergency admissions.	
The data evidence better curative rates for early-stage disease and excellent pathological confirmation rates for early-stage disease and good PS.		Many of the HB patients have high PS and present with advanced disease making curative treatment less viable.	
More patients with SCLC having chemotherapy.		Surgical resection rates are under target, although have improved since 2021, under the 17% target set by NLCA.	
Increase from 31.7% to 57.1% of NSCLC with stage IIIA and PS 0-2 receiving curative treatment.		High rate of emergency presentations (41.3%).	
Lung Cancer Nurse Specialist input very good with plans to see inpatients.			
Adjusted one year survival rate is second best in Wales at 44.8%.			
Actions:		Progress:	Update:
Lung Health Check Pilots - No imminent HB plans - Discussions needed with Division		Ongoing	Nov 2024
Surgical resection rate below NLCA target - No issues with access but waiting times >4 weeks - resource discussion to be held with the division			
Ongoing oncology and surgical delays - Improved pathological services – PD-L1 in-house from next month, QuicDNA ctDNA project pioneers			
The only Data Quality measure that the Health Board is not meeting is Morphology (all patients) 69%			

23/23115/31

Audit Name:	Report Title:	CSEG Date:	Clinical Lead:
NOGCA - National Oesophago-Gastric Cancer Audit	National Oesophago-Gastric Cancer Audit State of the Nation Report	May 2024	Dr Tamsin Boyce, Consultant, Surgery

Successes:		Concerns:	
1	Doing well with CT Staging at 96.9% higher than the national rate.	1	Lower rates of patients having a plan for curative treatment than the national rate, the Health Board being 32.4% and nationally 37.2%.
2	Of the patients with a plan for non-curative treatment, 42.8% are having chemotherapy or radiotherapy, nationally this is 34.7%.	2	The Health Board has a lower rate for patients having a plan for non-curative treatment at 67.6% compared to nationally 62.8%
3	With higher diagnosis rate in the Health Board compared to eh rest of Wales, the Health Board maintained face to face contacts and MDT's during the pandemic.	3	Increase in RTT 62-day measure, form 80 days in 201/-2020 to 82.5% in 2020/2022.
4	Lower rates of diagnosis after emergency admissions than other organisations across Wales, although not a good at the UK national rate. ABUHB 14.1% v National 13.1%.		
5	Straight To Test endoscopy CT scans done same day if applicable.		

Actions:	Progress:	Update:
Patient pathways are being reviewed at a national level (National Optimal Pathway) to reduce late-stage diagnosis and to reduce the proportion of patients waiting longer than 62 days. Service Level Agreement (SLA) in progress.	Targets for improvement are defined as part of the National Optimal Cancer Pathway. Delivery of this in ABUHB is monitored through the Cancer Operational Delivery Group	November 2024
Specialist OG dietician in clinic however further input is required as there is a workload.		
Treatment is delivered by Cardiff and Vale UHB which can cause delays in treatment resulting in delays, which has been addressed and improved upon.		

Audit Name:	Report Title:	CSEG Date:	Clinical Lead:
Fracture Liaison Service – Data Base	Annual report - Improved FLS identification with gaps in monitoring: a call to action for national and regional planners	May 2024	Dr Inder Singh – Consultant in Care of the Elderly Medicine

Report Successes:	
1	KPI 2 - Case Identification has increased from 22.6% in 2021 to 42.6% in 2022 with a further increase in 2023 to 54.1% , and from 2022 to 2023 increased from red into amber and is performing better than Wales and National average.
2	KPI 3 – Spine Fractures metric is >20% is green, and in 2021 was 26.1% , in 2022 the increased to 35.4% and a further increase in 2023 to 44.6%
3	KPI 4 – Assessment within 90 days has increased from 21.3% and red in 2021 to 60.3% and amber in 2023 remained amber but increased to 74.2% and although worse than the Wales average is better than the National average
4	KPI 6 – Falls risk assessment was 34.7% in 20021 however significantly increased to 80.2% in 2022 and a further increase in 2023 to 96.6% , this measure green if over 50%
5	KPI 7 – Bone treatment has a lesser growth although all years are in the green at 57.7% in 2021, 65.7% in 2022 and 67.5% in 2023
6	KPI 9 - 16 week follow up have significantly improved from 1.4% in 2021 to 19.1% in 2022 and a significant increase to 64.4% in 2023 and performing considerably better than the Wales and National averages, therefore a concern previously and now a success

S.M.A.R.T Actions ongoing:
Based on the annual activity/no. of fragility fractures ABUHB FLS of 4209, The HB needs 4.7 - WTE nursing staff 2.5 - admin 0.6 - radiology staff (dexa scan) 0.2 consultant. The total annual cost for this is £433,987. The Medical Division has invested 2 WTE CNS and 1 WTE Administrator (147K). Over the period of 5 years the total annual cost for ABUHB FLS including staff cost, overhead charge of 15% and prescribing costs be approx. £450,376 to £883,488. The annual benefits across acute care is equal to £1439,436 and all benefits inclusive of community and social care will be 2.1 Million. FLS is regularly discussed in Falls and Bone Health Committee but with Patient representation and ROS representation

Report Concerns:	
1	KPI 5 – Dex scan with 90 days was 23.3% in 2021, this decreased in 2022 to 12.4% and a further decrease in 2023 to 9.4%
2	KPI 8 – Strength and balance by 16 weeks is red for all years at 4.8% in 2021 and 9.1% in 2022 and 10% in 2023 which is increasing and is performance better than the Wales and National average
3	KPI 10 – Treatment by 1 st Follow up although remains in the red, the performance has increased from 8.3% to 18.1% to 47.3%
4	KPI 11 – 1 Year drug adherence for 2022 the Health Board is under performing compared to the Wales and National average at 13.6%. No comparison data for 2023 is available to date

Local - S.M.A.R.T Actions:	Responsible:	Due Date:
FLS for the ABUHB continues to be a centralised service and this is already achieved, however this needs to be continued.	Dr Singh	November 2024
Wider partnership with Community Team, Primary Care and third sector.		

Audit Name:	Report Title:	CSEG Date:	Clinical Lead:
NAD - National Audit of Dementia	Care in General Hospitals 2022-2023 Round 5 Audit Report	May 2024	Dr Inder Singh – Consultant in Care of the Elderly Medicine

Report Successes:		Actions:	Progress:	Update:
1	Pain Assessment and re-assessment in RGH at 100% and YYF pain assessment 82%	Dementia alert on CWS in practice and currently linking with Improvement Cymru in establishing a benchmark (once achieved CL will be establishing other metrics inc. IP Falls)	Ongoing	Nov 2024
2	Delirium Screening noted on admission - RGH 98% and YYF 94% compared to national 87%	Dementia training and awareness is ongoing. Good Work Learning and Development Framework level 1. - Informed level 86% on ESR - Skilled level bi-annual reporting to WG - Influencer level presenting on boards, meetings and conferences Annual Dementia Statement gone to Board and review led by senior nurse Clinical Lead and senior nurse report to the Board regularly All areas identified for improvement are management by the senior nursing team		
Report Concerns:				
1	EDD - RGH - 5% within 24 hours, 39% more than 24 hours, 57% initiated NHH - 3% within 24 hours, 16% more than 24 hours, 81% not Initiated - difficulties with EDD due to patient complexities and delays in social measures YYF - not enough data to analysis			
2	Pain Assessment NHH 69%			
3	Lack of use of the Abbey Pain Score tool			
4	Discharge planning not carried out within 24 hours for RGH and not completed in NHH - lack of data for YYF			
5	Length of Stay median: RGH 17 days NHH 13 days YYF 33 days			
6	Pain re-assessment for YYF 22%			
7	Delirium Screening NHH - 70%			
		IT developed report for dementia code		
		To continue with pain assessment using Care Flow question only assessment		

Clinical Standards and Effectiveness Group – July 2024

Audit Name:	Report Title:	Clinical Lead:
All Wales Audiology Audit	Audiology audit	Dr Davida Hawkes - Consultant Paediatrician
NDA - National Diabetes Audit (adults)	National Diabetes Foot Care Audit (NDFA) State of the Nation report, 01/04/2021- 31/03/2022 TBC; Eng & Wal.	Melissa Blow - Clinical Lead Podiatrist Diabetes and Tissue Viability, Podiatry
NPDA - National Paediatric Diabetes Audit	National Paediatric Diabetes Audit annual core state of the nation (01/04/2022 - 31/03/2023)	Wendy Trump - Clinical Scientist, Head of Audiology Services, Audiology
Sentinel Stroke National Audit (SSNAP) – State of the Nation Annual Report 2023	SSNAP Annual Report 2023 Sentinel Stroke National Audit Programme Stroke care received between April 2022 to March 2023	Rhys Monk Dir. Manager for Stroke

Audit Name:	Report Title:	CSEG Date:	Clinical Lead:
All Wales Audiology	Report on the 2022 National Audit of Quality Standards for Adult Hearing Rehabilitation Audiology (Wales)	July 2024	Wendy Trump - Clinical Scientist, Head of Audiology Services, Audiology

Report Successes:		Report Concerns:	
1	1a.1 Excellent detailed pathways were seen throughout the audit. Ideal for new and existing staff to refer to.	1	Accessing the service one criteria scored 0 - Since Covid the department have been unable to maintain 14-week RTT for existing and new patients. Covid also led to the suspension of the volunteer service. Plans are in place to address the above.
2	2a.6 Good evidence of feedback from service users.	2	Implementing an Individual Management Plan one criteria scored 0 - No plans to currently offer a 3 years reassessment This applies to all Audiology Services across Wales
3	3a.7 Staff are always being supported and encouraged to participate in learning new processes and to review existing.		
4	5c.2 Good referral pathway to Hearing Therapy services.		

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:
1	To reduce waiting time for new and existing patients	To liaise with the Directorate management to increase capacity	Wendy Trump/Directorate management team	Nov 2024
2	Address low scoring criteria linked to long waiting times.			
3	Version 3 is out for consultation to address weakness in V2 and include changes to Audiology practices.			

Audit Name:	Report Title:	CSEG Date:	Clinical Lead:
National Diabetic Foot Care Audit	National Diabetes Foot Care Audit (NDFA) Are services providing effective diabetes foot care?	July 2024	Melissa Blow - Clinical Lead for Podiatrist Diabetes and Tissue Viability

Report Successes:		Report Concerns:	
1	ABUHB First Expert Assessment (FEA) within 0-13 days after referral during 2022-23 was 78.4% within a range of 82.4% - 50.0% across Wales. The target has been set at being more than 70% (0-13 days) by 2026. (Professional and Self-referrals)	1	ABUHB AAUF rate was 22.2% and this ranged from 56.3% to 21.7% across Wales – although the data does not reflect the complexities of ABUHB patients in 12 weeks (less severe ulcer in more complex patients) – work planned to improve on this result
S.M.A.R.T Actions:		2	% self-referrals for ABUHB was 17.8%, with a range of 46.9% to 11.1% across Wales. Self-referral access generates higher levels of AAUF at 12 weeks – Each HB was recording slf referral different and national agreement on this has been achieved
ICBs and Welsh LHBs should ensure that specialist clinical foot care services are accessible to all people with diabetes related foot ulcers and are appropriately resourced.		The service does not have electronic processes and uses paper processes which affects staff workloads and can impact data recording. Ascertainment rates are continuously promoted and monitored.	
Achieved across the 5 boroughs and looking to introduce a drop-in clinic in Newport, Caerphilly and Monmouthshire.			

Audit Name:	Report Title:	CSEG Date:	Clinical Lead:
National Paediatric Diabetes Audit (NPDA)	National Paediatric Diabetes Audit (NPDA) Report on Care and Outcomes 2022/23	July 2024	Dr Davida Hawkes, Consultant Paediatrician

Report Successes:		Report Concerns:	
1	ABUHB paediatric diabetes team continue to reduce HbA1c, reducing to Alert status and no longer Alarm status and we are Reducing the gap	1	Other teams continue to improve so always playing catch up
		2	Business case has not resulted in investment in the service to date

S.M.A.R.T Actions:	Responsible:	Due Date:
A business case was previously approved however no funding was allocated – funding to be sought for technologies	Requires Exec Board approval	Immediately
Awareness of onset of Type 1 diabetes requires a relaunch of interaction with Primary Care	Dr Davida Hawkes	Nov 2024

Audit Name:	Report Title:	CSEG Date:	Clinical Lead:
SSNAP	SSNAP Annual Report 2023 Sentinel Stroke National Audit Programme – State of the Nation Stroke care received between April 2022 to March 2023	July 2024	Rhys Monk – Directorate Manager for Acute Stroke Services

Report Successes:		Report Concerns:	
1	69% of patients spent at least 90% of their hospital stay in a specialist stroke unit compared to 73% nationally ~ ABUHB 68% 2021/2022	1	51% of applicable patients received swallow screening within 4 hrs of admission compared to 72% nationally ~ ABUHB 56% 2021/2022
2	92% of patients were assessed by stroke specialist within 24 hrs of admission compared to 83% nationally ~ ABUHB 92% 2021/2022	2	20.1% of patients were directly admitted to a stroke unit within 4 hrs of hospital arrival compared to 40% nationally ~ ABUHB 23 % 2021/2022
3	12.7% of all stroke patients received compared to 10.7% nationally thrombolysis ~ ABUHB 11.8% 2021/2022	3	73% of patient received stroke specialist nursing assessment within 24 hrs of admission compared to 89% nationally ~ ABUHB 90% 2021/2022
4	Thrombolysis rates are within range as per GIRFT (15-20%)	4	50% pf patients received brain imaging within 1 hr of hospital arrival compared to 57% nationally ~ ABUHB 58% 2021/2022
5	Implementation of BRAINOMIX AI decision support tool	5	17.1% of applicable patients directly admitted to a stroke unit within 4 hours of clock start AND who either receive thrombolysis or have a pre-specified justifiable reason ('no but') for why it could not be given compared to 40.1% nationally ~ ABUHB 22.1% 2021/2022
6	Reconfiguration of Rehabilitation Services to centralise in YYF, resulting in increased throughput on the HASU and reduced LOS (+4 patients per week, and -0.8 days respectively).	6	Getting patients to HASU within 4 hours of presentation, this is covered in the paper and presentation, as well as a proposal to improve this
		7	Recruitment of Senior Medical Staff, we are exploring the opportunity to appoint Specialist Doctors to backfill vacant Consultant posts
		8	Therapies staffing levels, circa 50% below recommended levels
		9	6-month follow-up metrics 0% - this will improve going forward now that the CNS team are returning from Maternity Leave.

	Local recommendations:
1	Review of Medical JDs and job plans to make them more attractive
2	Adjustment of frequency of high-intensity weeks to reduce Consultant burn out on the HASU
3	Development of live dashboard to give real time performance data (need organisational support to do this)
4	Proposal to ring fence stroke beds

Clinical Standards and Effectiveness Group - Processes:

Healthcare Quality Improvement Programme (HQIP) Provide regular updates on when reports will be published. Often dates will change. QPS will inform the Clinical lead and the Divisional Triumvirate of these planned dates and of any amended dates and invite to present the Health Board data at the most appropriate CSEG.

Once the report is published, QPS will insert local data into a PowerPoint document and organise a meeting with the presenter to ensure its accuracy and to ensure that AMaT is reflective of the data.

Meeting Summary Logs:

- The meetings notes have developed over recent months into meeting summary logs, which are more succinct in terms of text, however the audit presentations are included in a slide deck for further audit information. All relevant documents are available for all Health Board staff on the Quality and Patient Safety (QPS) intranet page, [here](#).
- QPS liaise with the Clinical Lead or Divisional/Directorate Management prior to CSEG to ensure all actions are based on the report recommendations and to detail any local actions which are S.M.A.R.T. and these are given a six-month review date.

What's Next.....

The QPS team will monitor and request action updates at a 6 month point review with the relevant person(s) which will be added to the appropriate CSEG meeting as an update. All national audits should be signed off before or around the time of new publications – an audit cannot have more than one report ongoing. When a report is not annual, a 12-month review by QPS will take place

The processes have developed to ensure better communications while streamlining processes and remain being fit for purpose. The above pathway is being updated in the Clinical Audit Policy which is currently being reviewed for submission to the Clinical Standards Policy Group (CSPG).

Risk and Assurance

AMaT had pre-defined Assurance and Risk levels, which were used initially, however QPS met with the Head of Corporate Risk and Governance to ensure that the Assurance and Risk levels in AMaT align to the Health Boards NEW Risk Management Framework and Policy.

If any of the audits presented have a risk level from Minor to Catastrophic, then these are expected to be placed on the relevant risk register. There have been examples where a minor or moderate risk has been identified, but not placed on a risk register as at that time the service were still working on S.M.A.R.T. actions to mitigate the risk.

Previous Assurance and Risk Levels

Assurance Level (AMaT)	Description
Full	The project has fully achieved the standards or criteria being audited against
Significant	The project has mostly achieved the standards or criteria being audited against
Limited	The project did not achieve the standards or criteria being audited against
Very limited	The project failed to achieve the standards or criteria being audited against

Risk level	Description
None	Standards met and findings demonstrate no risk to patient safety
Low	Peripheral element of treatment or service suboptimal
Minor	Single failure to meet internal standards/Minor implications for patient safety if unresolved
Moderate	Repeated failure to meet internal standards/Major patient safety implications if findings are not acted on
Major	Non-compliance with national standards/Significant risk to patients if unresolved
Catastrophic	Gross failure of patient safety if findings not acted/ Gross failure to meet national standards

New levels in accordance to the Health Boards Risk Management Framework and Policy

Assurance Level (AMaT)	Description
Full	The project has fully achieved the standards or criteria being audited against
Significant	The project has mostly achieved the standards or criteria being audited against
Limited	The project did not achieve the standards or criteria being audited against
Very limited	The project failed to achieve the standards or criteria being audited against

Risk Level (AMaT)	Description
None (Negligible)	Standards met and findings demonstrate no risk to patient safety
Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved
Moderate	Treatment or service has significantly reduced effectiveness - Moderate risk to patient safety if not acted upon
Major	Non-compliance with national standards with significant risk to patients if unresolved - Major risk to patient safety
Catastrophic	Totally unacceptable level or quality of treatment/service - Gross failure to meet national standards - Gross failure to meet standards

The Clinical Lead is responsible for ensuring that the audit can be signed off, which means the assurances are in place, conclusions noted, audit results are summarised as a list of successes and concerns, and action plans completed and that NO S.M.A.R.T. ACTIONS ARE LEFT UNCOMPLETED (Action completion is tracked by governance team)

AUDIT ACTIONS ON AMaT:

Audit actions can take time to be completed, often cascading over more than one 12-month period. To date, the following audit have been closed, the years relate to the year the audits were registered (i.e. this may not be when audit was completed as reporting of some audits can be delayed).

Audit completion is monitored by the Quality and Patient Safety (QPS) team to ensure appropriate and timely closure.

Row Labels	2020-21	2022-23	2023-24	2024-25	Grand Total
Acute Medicine	1				1
Anaesthetics			1		1
Family & Therapies			1		1
General Surgery				1	1
Menopause Service			1		1
Paediatrics		1			1
Rheumatology		1			1
Sexual and Reproductive Health		5	5		10
Trauma and Orthopaedics			2		2
Urology			1		1
Mental Health				1	1
Grand Total	1	7	11	2	21

ACTIONS IN WARD AREA:

The ward area of AMaT allows wards to undertake local audit. These routine audits take place every day, these result in actions being allocated to staff within those areas to action. It is the responsibility of the lead participant or the ward manager to ensure the actions are managed accordingly.

The data below shows 400 total actions, 281 of these actions have been fully completed:

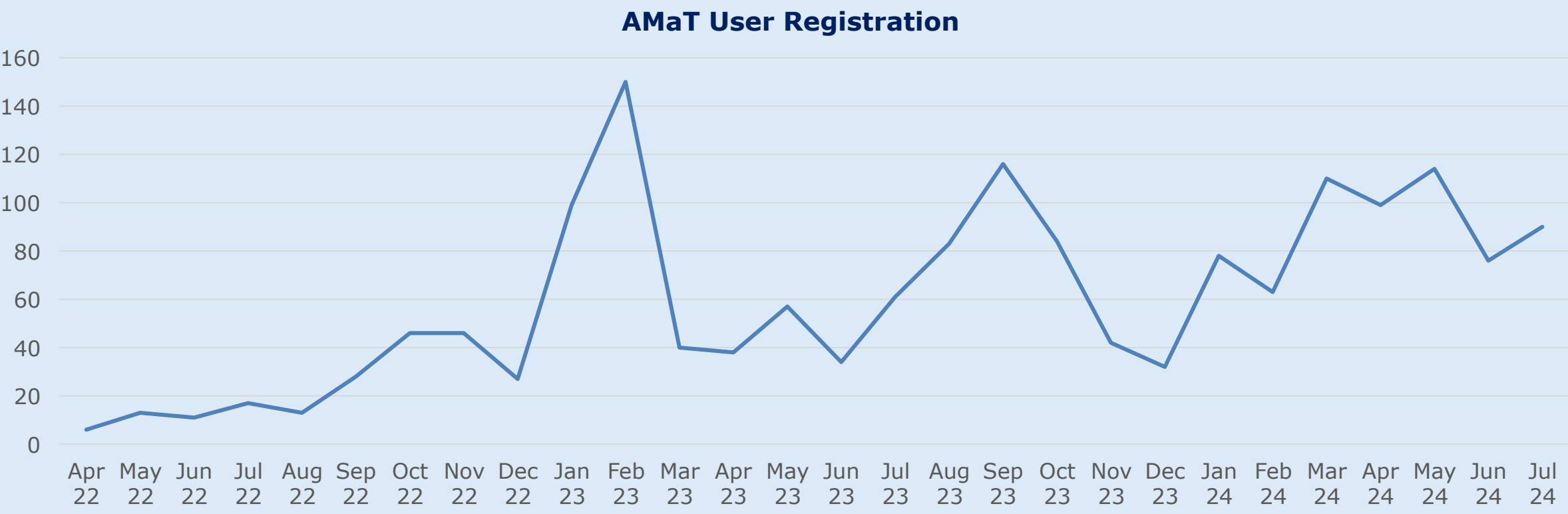
Action no longer relevant	1
Fully Complete	281
New	38
Overdue	73
Partially complete	6
Partially complete (Overdue)	1
Grand Total	400

These actions are taking place across the Health Board:

County Hospital	17
Grange University Hospital	64
Llanfrechfa Grange Hospital	6
Monnow Vale	2
Nevill Hall Hospital	186
Royal Gwent Hospital	70
St Cadoc's Hospital	1
St Woolos Hospital	10
Ysbyty Ystrad Fawr	8
Ysbyty'r Tri Chwm	36
Grand Total	400

AMaT Users across the Health Board

The Clinical Audit Strategy has been presented at Divisional meetings to ensure engagement. This also provided the opportunity to demonstrate the use of AMaT to capture, analyse and report all audit data. Directorate and ward staff have also received training on AMaT. The QPS Audit team have worked with users to assist in registering, building proformas and running reports on data. Staff continue to register to use AMaT daily as demonstrated by the ongoing increase in user registration.



Resource

- The November 2022 internal audit report stated:
 - 'Additionally, there is no evidence that the Health Board has considered whether it has the resource at an operational level to ensure clinical audit is carried out to a high standard and any resulting actions are implemented. This is also included within the Health Board needs to formalise the Clinical Audit Strategy and consider whether it has given enough resources to those responsible for clinical audit to carry out the Strategy.'
- Part of this year's workplan looks to address this, by completing the following actions:
 - The QPS audit team will be carrying out a benchmarking exercise to review the resources in external organisations comparable in size to Aneurin Bevan University Health Board.
 - This will review the data acquisition resource to ensure full and effective participation in the National Clinical Audit (NCA) programme and the Clinical Outcome Review Programmes (CORP).
 - The infrastructure of clinical audit teams will also be assessed, to consider the resources in other organisations to enable tracking and monitoring of audit recommendations.
 - This will allow a gap analysis to be developed and an assessment of the risk associated with the gap.
 - The QPS team hold all relevant information relating to the National Clinical Audit Outcome Review Plan and keep this updated

Further work

- The Clinical Audit Policy for the Health Board has been updated and includes standard operating procedures for:
 - National Clinical Audit Reporting and Monitoring Procedure
 - National Clinical Audit Outlier Procedure
 - National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - National Clinical Audit and Outcome Review Plan (NCAORP)
- The Terms of Reference for the Clinical Standards and Effectiveness Group are being reviewed to reflect changes in processes as a result of HIW recommendations
- Divisions are kept informed of actions that are being undertaken in their areas and actions that are overdue for completion
- The QPS team are continuously monitoring updates from HQIP
- The QPS team hold all relevant information relating to the National Clinical Audit Outcome Review Plan and keep this updated
- The QPS team engage with national audit providers, such as NACEL and NRAP (delivered by Royal College of Physicians under contract from HQIP) to ensure participation
- The QPS team are working on producing a newsletter for each division providing details of all audit activity - the first division to receive this is the surgery, example provided in next slide.



44 local audits registered pre 2024/2025 with 18 new registrations for this year

- **3 audits have overdue actions**
- **4 audits have actions that need attention**
- **5 audits have completed actions**

What has happened this year so far...

Presented to the Clinical Standards and Effectiveness group (CSEG) in January 2024 was.....

- National Early Inflammatory Arthritis Audit – State of the Nation report 2023 – signed off and due October 2024
- National Vascular Registry - State of the Nation report 2023

And in CSEG March 2024.....

- National Bowel Cancer Audit - State of the Nation report
- National Prostate Cancer Audit - State of the Nation report & Prostate Cancer Services during the Covid 19 pandemic
- National Oesophago-Gastric Cancer Audit - State of the Nation report

What's ahead...

What will happen in the remainder of the year.....

- ❖ NCEPOD Testicular torsion report
 - ❖ NATCAN – National Cancer Audit Collaborating Centre will be publishing 6 new reports
- Reports from NATCAN due 12th September 2024*

- **Recommendations: 21**
Some recommendations are outside of HB remit
- **Already being achieved: 5**
- **Actions on going: 4**
- **Actions fully completed: 1**
- **Overdue action(s): 1**

NNHLA – Non-Hodgkin Lymphoma
NOCA – Ovarian
NPaCA – Pancreatic
NKCA – Kidney
NaoPri – Primary Breast
NaoMe – Metastatic Breast

ABUHB Clinical Audit Strategy
can be found [here](#)

National Clinical Audit
Outcome Review Programme
can be found [here](#)

Audit Publication dates can be
found [here](#)



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	12 September 2024
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Counter Fraud Progress - Q1 2024/25
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Robert Holcombe, Director of Finance, Procurement and Value Based Healthcare
SWYDDOG ADRODD: REPORTING OFFICER:	Nicola Tillings, Interim Head of Counter Fraud

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

Er Gwybodaeth/For Information

To update the Audit, Risk and Assurance Committee of the work of the Counter Fraud Team.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report has been prepared for the Aneurin Bevan University Health Board’s Audit, Risk and Assurance Committee. It highlights the Counter Fraud work which has been undertaken by the Local Counter Fraud Specialist (LCFS) specifically during Q1 and to date during financial year 2024/25.

Cefndir / Background

This document has been prepared by the Aneurin Bevan University Health Board Counter Fraud Team to comply with the legal directions and the NHS requirements of the Government Functional Standards S013.

1 Staff awareness

Counter Fraud awareness input at Corporate Induction remains a mandatory requirement. During Q1 of the current financial year 75 members of staff have completed Corporate Induction which includes fraud awareness.

In February 2024, the ESR Counter Fraud E-Learning module was mandated for ABUHB staff. During Q1 a total of 3,095 staff completed the on-line training course, bringing the total staff completion to 10,247 - 66.5% of ABUHB employees as at 30th June 2024.

The Team welcomed the opportunity to have a stand at the Healthcare Professionals & Healthcare Scientists Conference that was held in Newport on 12th July 2024, the event was attended by approximately 190 ABUHB staff. Counter Fraud were well received, with staff interaction resulting in requests for in-person Counter Fraud Awareness sessions, with two events scheduled for Q2/Q3 (Hearing & Balance Unit Directorate meeting September 2024 and Dietetics Directorate, provisionally October 2024 tbc).

2 Proactive Work

Fraud Prevention Activity /Local Proactive Exercises (LPE)

During Q1, 3 Fraud Alerts were issued to primary care contractors, two were in relation patient prescription frauds, the other to Independent Prescribers in the South East Region (dental surgeries, opticians, including GPs where applicable and pharmacies) reminding them of their responsibilities regarding prescribing practice in relation to the issue of WP10 prescriptions.

Reactive investigation work was priority during Q1. During Q3 emphasis/priority will be assigned to Risk Assessments to ensure we meet the required standards/current Counter Fraud Workplan objectives.

3 Reactive Work

The table below summarises the Counter Fraud Team operational data and sanctions secured during Q1 2024/25. The team were investigating **28** cases as at 1st April 2024 – **24** new referrals were received, **21** cases closed, with **31** open investigations as at 30th June 2024. There were 6 civil sanctions recorded during this period, with total financial recoveries of **£86,160**. The majority of this recovery is as a result of Counter Fraud’s investigation/intervention into overpayment of salary cases.

Referrals Q1	Cases Closed Q1	Financial / Civil Recovery		Open Cases as at 30/06/24	Sanctions Q1	
		Q1	Cumulative 2024/25		Civil	Internal Disciplinary
24	21	£86,160	£86,160	31	6	1

During the reporting period, 4 subjects were formally Interviewed Under Caution, these investigations are continuing. One file was submitted to the Crown Prosecution Service (CPS) for charging consideration, decision is pending/awaited. One member of staff was disciplined resulting in a Final Formal Warning.

A sanitised list of open cases as at 30th June 2024 is included at **Appendix 1**.

4 Head of Counter Fraud

A recruitment exercise took place during Q1 for a new Head of Counter Fraud. Gareth Lavington, currently Head of Counter Fraud for Cardiff & Vale UHB was successfully appointed and is to commence in post on Monday, 2nd September 2024. In the interim, to ensure continuity a current Counter Fraud team member is covering the position following the departure of Michelle Morris at the end of June 2024.

Argymhelliad / Recommendation

This report is intended for Audit, Risk and Assurance Committee’s information.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Finance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.

Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

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

APPENDIX 1

No.	Case No	Date Opened	Subject	Offence	Case Summary
1	INV/24/01508	14/06/2024	Doctor	Salary Overpayment	Enquiries established not for fraud to pursue - referred to Accounts Receivable (pending closure/Q2)
2	INV/24/01199	13/05/2024	NHS Staff	Salary Overpayment - GB	Investigation ongoing
3	INV/24/00993	19/04/2024	NHS Staff	False claiming for shifts	Investigation ongoing
4	INV/24/00857	05/04/2024	NHS Staff	Unauthorised access to OMNICELL	Investigation ongoing
5	INV/24/01318	23/05/2024	Nurse	College course while on sick leave	Investigation ongoing
6	INV/24/01310	22/05/2024	HCSW	Salary Overpayment	Investigation ongoing
7	INV/24/01290	21/05/2024	Admin	Covid Mass-Vaccination salary overpayment	Investigation ongoing
8	INV/24/01241	14/05/2024	HCSW	Salary Overpayment	Investigation ongoing
9	INV/24/01205	13/05/2024	Nurse	Salary Overpayment	Investigation ongoing
10	INV/24/01204	13/05/2024	District Nurse	Salary Overpayment	Investigation ongoing
11	INV/24/01180	08/05/2024	Nurse	Salary Overpayment	Investigation ongoing
12	INV/24/01085	29/04/2024	Patient	False info in respect of clinical negligence claim	Investigation ongoing
13	INV/24/00945	16/04/2024	Security Officer	Working while sick	Investigation ongoing
14	INV/24/00944	16/04/2024	Facilities Staff	Breach of leave policy	Investigation ongoing
15	INV/24/00491	28/02/2024	NHS Staff	Timesheet/Failure to Complete Contracted Hours (secondary employment)	Investigation ongoing
16	INV/24/00480	27/02/2024	NHS Staff	Working While Sick	Investigation ongoing
17	INV/24/00361	14/02/2024	Pharmaceutical Contractor	False/Inappropriate Claims	Investigation ongoing
18	INV/24/00204	26/01/2024	Consultant	Salary Overpayment	Investigation ongoing
19	INV/24/00191	25/01/2024	Scientific/MTO	Abuse of NHS Services/Charge Evasion	Investigation ongoing
20	INV/23/02427	27/10/2023	HCSW	Salary Overpayment	Investigation ongoing
21	INV/23/02342	18/10/2023	NHS Staff - Consultant	Working privately while sick and during NHS Contracted Hours	Investigation ongoing
22	INV/23/02253	10/10/2023	NHS Staff (Facilities)	False/Misleading information for Special Leave	Investigation ongoing
23	INV/23/01741	18/08/2023	NHS Staff (Nurse)	Salary Overpayment	Awaiting payroll overpayment calculation
24	INV/23/01532	31/07/2023	NHS Staff (Hospital Doctor)	Salary Overpayment	Subject failed to engage - referred to Debt Management (case closure pending update)
25	INV/23/01521	28/07/2023	NHS Staff	Timesheet Fraud	Investigation ongoing
26	INV/23/01520	28/07/2023	NHS Staff (Nurse)	Salary Sacrifice/non-payment (lease vehicle)	Investigation ongoing
27	INV/23/00761	20/04/2023	NHS Staff	Working while sick	Fraud NFA - Referred to HR for disciplinary consideration
28	INV/23/00920	19/04/2023	NHS Staff	Timesheet / Annual Leave fraud	Referred to HR for disciplinary investigation, civil repayment pending
29	INV/23/00258	06/02/2023	Dental Nurse	Timesheet fraud.	GDC disciplinary pending (civil recovery / repayment plan)
30	INV/22/01414	04/10/2022	NHS Staff	Salary Overpayment	Awaiting HR disciplinary decision, civil recovery in progress
31	INV/22/01184	26/08/2022	NHS Staff	Timesheet fraud	NFA criminal - awaiting disciplinary outcome



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	12 September 2024
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Audit, Risk and Assurance Committee – Review of Committee Forward Work Plan 2024/25
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Corporate Risk and Assurance

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

The Audit, Risk and Assurance Committee (the Committee) is asked to review the agreed Committee Forward Work Plan appended to this report as **Appendix A**.

The Forward Work Plan has been developed with due regard to recommendations from the Committee Self-Assessment 2023/24 and to enable the Committee to: -

- Fulfil its Terms of Reference;
- Seek assurance and provide scrutiny on behalf of the Board, in relation to those items identified within the Committees terms of reference, and,
- Seek assurance that governance, risk, and assurance arrangements are in place and working well.

Cefndir / Background

In line with good governance practice, the Committee has a Forward Work Plan that has been developed to ensure statutory requirements for items of Committee business are scheduled in across the year. The Forward Work Plan can therefore be utilised as a tool for informing and pre-empting Committee business and support the agenda setting process. The Forward Work Plan is designed to assist the Committee in the review of its programme of business. It captures the timing of report submissions, identifies items that have been deferred, and captures new requests for reports. The plan also allows the Committee to monitor and review its business at each meeting. During the period of July to September 2024 the following requests and/or changes to the Forward Work Plan have been included: Items deferred on the Forward Work Programme - Annual Review of Committee Effectiveness 2023/24 to include a review of the Terms of Reference - Deferred to November Amendments or Additional Items Added - There have been no requests for amendments or additional items to be included. <u>Argymhelliad / Recommendation</u> The Committee is requested to NOTE the updated Audit, Risk and Assurance Committee Forward Work Plan as provided in Appendix A.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The monitoring and reporting of committee business is a key element of the Health Boards assurance framework
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Committee Forward Programme monitors delivery of objectives.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance

Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

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

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

<https://futuregenerations.wales/about-us/future-generations-act/>

ANNUAL PROGRAMME OF BUSINESS 2024/25

AUDIT, RISK & ASSURANCE COMMITTEE

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

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

Area of Focus as per Standing Orders:

The Audit, Risk and Assurance Committee will provide assurance to the Board of the effectiveness of its arrangements for handling reservations and delegations.

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

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

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

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

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

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

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2024/25					
			Quarter 1		Quarter 2		Quarter 3	Quarter 4
			16 th April 2024	May 21 st <i>Draft Accounts</i>	July 9 th <i>Final Accounts</i>	12 th Sept 2024	12 th Nov 2024	18 th Feb 2025
Total Items Scheduled (excluding preliminary items) -to be updated prior to each meeting			10	15	15	12	15	16

Audit, Risk and Assurance Committee Members to meet Independently with:								
External Audit Team	BI	Chair			√			√
Internal Audit Team	BI	Chair		√			√	
Local Counter Fraud Team	BI	Chair	√			√		

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

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

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	12 September 2024
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Implementation of the Governance Priorities set out within the Integrated Medium-Term Plan 2023-26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Corporate Governance

**Pwrpas yr Adroddiad
Purpose of the Report**

Er Sicrwydd/For Assurance

The purpose of this paper is to provide the Audit, Risk & Assurance Committee with an update in respect of implementing the governance priorities set out within the Integrated Medium-Term Plan 2023-26.

**ADRODDIAD SCAA
SBAR REPORT**

Cefndir / Background

Aneurin Bevan University Health Board (ABUHB) recognises the importance of governance in ensuring that the organisation fulfils its overall purpose, achieves its intended aims and outcomes for our population, and operates in an effective, efficient, and ethical manner. The effectiveness of its governance arrangements will therefore have a significant impact on how well the Health Board delivers its vision, aims and objectives.

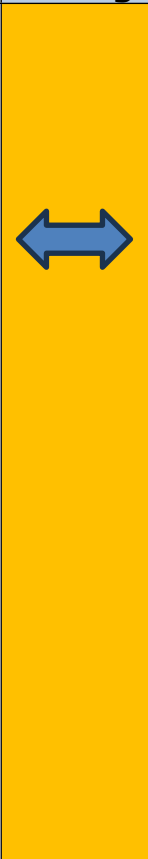
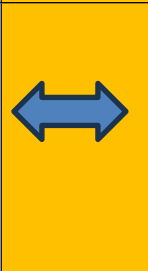
Within the Integrated Medium-Term Plan 2023-26, the Health Board set out its commitment to continually reflect upon, developing and maturing our governance systems to ensure that the organisation has a strong focus on integrated governance and leadership across quality, finance and operations as well as an emphasis on organisational culture, improvement and system working. In doing so, it aims to continuously ensure that the Health Board is a well-led organisation with effective, agile and proportionate structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, which are clearly set out and understood.

The Integrated Medium-Term Plan set out the governance improvement priorities, focussed on further strengthening the Health Board’s governance arrangements, ensuring they are robust and fit for purpose, responding to areas identified for improvement, informed by sources including Internal and External Audit and the Board’s reflections on its own effectiveness. These governance improvement priorities intended to:

- Ensure clarity of purpose, roles, responsibilities and systems of accountability;
- Ensure Board effectiveness; and
- Embedding an effective system of risk management and assurance.

Asesiad / Assessment

An update in respect of implementing the governance priorities set out within the Integrated Medium-Term Plan 2023-26, at the end of Quarter 2 2024/25, is provided below.

1. Ensuring Clarity of Purpose, Roles, Responsibilities and Systems of Accountability:		
Action	Update	RAG Rating
a) Establishing a Decision-Making Framework and an Accountability Framework to enable appropriate integrated-decision making at all levels of the organisation, along with strengthened internal control	The Health Board’s arrangements align to Standing Orders and Standing Financial Instructions (reviewed and approved September 2023). The Board’s Scheme of Delegation, including delegated limits, has been reviewed and will be presented to the Board for approval in September 2024. The Executive Team has been working with the organisation’s senior leadership team to further embed a culture of empowerment, autonomy, authority and accountability, building on existing arrangements in place. A Governance and Delivery Framework for Financial Recovery was approved by the Board in November 2023. In addition to these specific arrangements to oversee delivery of financial recovery and sustainability, the Board approved a Performance and Accountability Framework in September 2023.	
b) Developing a Partnership Governance Framework to support achievement of the Board’s objectives, where the involvement of our key partners is critical	Strengthened oversight of the Board’s statutory committees and joint committees has been established, with reporting to each meeting of the Board. A Governance Review of the Regional Partnership Board (RPB) has been	

	undertaken to review its governance model and understand the interface with the Health Board’s internal governance framework, to ensure clarity on decision making delegations and accountability. The review has concluded and reported to the RPB in September 2023. An action plan has been developed respond to the findings of the review. The action to develop a comprehensive Partnership Governance Framework, spanning all statutory partnerships, will be continued in 2024/25 and 2025/26.	
c) Further strengthening mechanisms for recording and reporting declarations of interest, gifts, hospitality and sponsorship.	The Health Board continues to operate under its approved policies to support Standards of Behaviour. A review of these policies has been undertaken. The revised Standards of Business Conduct Policy has been reviewed by the Audit, Risk and Assurance Committee and will be presented to the Board for approval in September 2024.	
2. Ensuring Board Effectiveness		
Action	Update	RAG Rating
a) Reviewing and strengthening the Board’s Committee Structure, aligning the Board’s needs with its assurance and advisory infrastructure	The Board established a revised committee structure in March 2022. The purpose of which was to better balance the focus between strategy, delivery, performance, and culture. The Board undertook a self-assessment against the NHS England Well-led Framework for Leadership and Governance Departmental Reviews in June 2023. The introduction of mid-year self-assessments by Committees to inform the year end Board Self-Assessment will take effect in 2024/25.	
b) Re-establishing the Board’s Advisory Structure, i.e. the Healthcare Professionals’ Forum and the Stakeholder Reference Group	The Board’s Advisory infrastructure requires the establishment of the Stakeholder Reference Group and Healthcare Professions’ Forum. The Executive Team has established a Clinical Advisory Group to advise it on strategic policy matters. An Options Appraisal which sets out existing arrangements for stakeholder and clinical engagement will be undertaken	

	to make recommendations to the Board on the most appropriate model for these two advisory functions. The Health Board's Local Partnership Forum (Trade Unions) continues to operate effectively.	
c) Ensuring openness and transparency in the conduct of board and committee business	The Health Board has introduced hybrid meeting arrangements for Board meetings, accommodating both in-person and virtual attendance. Recordings of meetings are also published to the website for viewing after the meeting. An implementation plan for the introduction of live streaming of Board-level Committees has been developed and will be established from October 2025.	
d) Further improving the quality of reports and information to the Board and its Committees	Revised report templates have been developed and will be developed and rolled-out with supporting guidance. The provision of report writing training is being secured for Executive Directors and Senior Managers, aligned to Board-level training on effective scrutiny and assurance.	
e) Implementing an annual development programme for Board members, focussing on awareness sessions as well as training and learning to support the development of individual roles and the Board as a cohesive team	The Board undertook a self-assessment against the NHS England Well-led Framework for Leadership and Governance Departmental Reviews in June 2023. This identified areas for improvement which were taken forward during 2023/24. A structured development programme will be established during 2024/25 onwards, ensuring the Board receives training on its core statutory responsibilities, as well as focussing on maturing its effectiveness and ways of working.	
f) Ensuring a programme of comprehensive recruitment and induction for Board Member appointments	During 2022/23, the Health Board introduced new induction arrangements for Executive Directors and Independent Members. This process remains under development to ensure its effectiveness, seeking feedback for new Board Members. The Health Board is due to commence recruitment for a Vice Chair and Independent Member (Third Sector) during 2024/25.	

g) Reviewing and implementing arrangements for the development, review, approval and publication of policies delegated by the Board	An Internal Audit review of the Health Board's policy management framework, undertaken in January 2023, concluded that the Health Board could take limited assurance that there are effective processes in place to manage policies and other relevant documentation. Overall, Internal Audit found that an appropriate and up-to-date framework and guidance document for the management of policies is in place. However, there are a significant number of policies and other documentation overdue for review. A Policy Management Improvement Plan has been established and has started to deliver improvements in compliance. The Framework and process for policy management has been reviewed and will be presented to the Board for approval in September 2024.	
h) Reviewing Board Champion Roles, ensuring clarity on purpose and responsibility	Board Champion roles were reviewed and re-affirmed by the Board in March 2022 and this will be reviewed in Quarters 3/4 of 2024/25 to reflect changes in board membership. National guidance on role profiles is awaited. Work will be undertaken in Quarter 1 of 2025/26 to establish clear arrangements and reporting from Champions into the Board's governance structure.	
3. Embedding an Effective System of Risk and Assurance		
Action	Update	RAG Rating
a) Further implementation of the Risk Management Strategy, ensuring it continues to be fit for purpose and supports the organisation to navigate risk management processes in a simplified manner	The Board approved the Risk Management Framework in January 2024. The Risk Management Framework, Procedure, and Risk Appetite Statement were communicated to the Health Board via AB Pulse, and all documents were published on AB Pulse's Policy page as well as the Health Board website. An email was sent to the divisional triumvirates to increase awareness and cascade through the hierarchy system.	

	Training within divisions has begun and will continue until all areas have received training; after that, requests for additional or refresher training can be submitted. There has been a noticeable improvement in risk inclusion on agendas and risk reporting through the governance and escalation process outlined in the Framework, as well as requests for assistance in developing risk assessments. Furthermore, the establishment of a Corporate Governance site on AB Pulse will include a dedicated risk management page, where staff will have access to risk management materials, training documents, and clips. As well as requesting training. The site is scheduled to 'Go Live' by the end of the calendar year (2024) and will be updated regularly to ensure staff have access to the most up-to-date information.	
b) Review the Board's Risk Appetite Statement, ensuring it is reflective of the organisation's capacity and capability to manage risks	The Board approved the Risk Appetite Statement at its meeting in January 2024 and is a component of the Risk Management Framework supporting Procedure and risk assessment template. This ensures that staff understand the risk appetite for the risks under consideration and can determine the scope of control and assurance required to manage the risk and reduce exposure.	
c) Prepare for implementation of a revised risk register reporting system to ensure it is comprehensive and aligned to the Corporate Risk Register (via Once for Wales Complaints)	The Risk Workstream, tasked with overseeing the development of a Once for Wales Risk Module, has reached a critical stage. Datix has requested that organisations migrate to the new Datix Cymru by November 2024, with further refinement possible after implementation. The Risk Group is	

Management System [DATIX])	concerned about the system's lack of critical core functionalities, reliable reporting capabilities, and overall readiness. Organisations that choose to continue using the legacy DatixWeb system until it is decommissioned in 2027, or seek a local solution, will incur additional costs as of 30 November 2024. However, there is a possibility that this matter will be escalated to the CEO Leadership Forum for further discussion, where the decision may be overruled and health bodies mandated to implement the Once for Wales Risk Management module. In the interim, work is underway to clean up and optimise the current DatixWeb system, ensuring that it is a functional and reliable risk management system, or to prepare for the migration to Datix Cymru.	
d) Further Embedding of the Board's Assurance Framework, aligned to the Corporate Risk Register	The Board Assurance Framework has been revised and is now integrated into the Strategic Risk Register (SRR) approach in accordance with the Risk Management Framework. The Strategic Risk Register includes strategic risks that are aligned with the organisation's strategic objectives and overall strategy. The Board and Audit, Risk, and Assurance Committee receive the full SRR at each meeting, while the other sub-committees receive all strategic risks related to their Terms of Reference for focused scrutiny and assurance on behalf of the Board. This approach ensures that all strategic risks are constantly monitored and reassurance about their management can be obtained.	
e) Introducing a system of Organisational Assurance Mapping at a divisional and directorate level to	Organisational mapping of internal controls and assurance arrangements has not yet commenced. The process for this work will be set out within the	

inform internal control arrangements	integrated Risk Management and Assurance Framework, which will include the Board Assurance Framework and supporting processes. This work will commence in 2025/26.	
Whilst progress has been made in delivering the required actions to achieve these objectives between during 2024, there remains further work to be delivered. To support this, a revised Director of Corporate Governance Structure, covering the breadth of corporate governance and corporate business elements and aligned to the governance priorities was developed with staff in post from the end of 2023. Following periods of induction this is now starting to provide the capacity and expertise within the team to drive forward the required changes, working with the wider organisation on key aspects.		
<u>Argymhelliad / Recommendation</u> The Audit, Risk & Assurance Committee is asked to receive this update for information, noting progress achieved to-date and those objectives which require further action.		

Amcanion: (rhaid cwblhau) Objectives: (must be completed)		
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	This paper outlines actions taken to strengthen organisational risk management arrangements.	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.	
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. This paper reflects on the Governance Priorities set out within the Integrated Medium-Term Plan 2023-26.	
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Choose an item. Choose an item. Choose an item.	
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.	

Gwybodaeth Ychwanegol:
Further Information:

Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Choose an item.



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	12 September 2024
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Welsh Health Circular and Ministerial Directions Tracking
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Bryony Codd, Head of Corporate Governance

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

Cefndir / Background

Welsh Health Circulars

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

For Aneurin Bevan University Health Board, WHCs are received from Welsh Government and issued via the Corporate Governance Team for action to the respective director leads/professional groups.

Ministerial Directions

Acts of Parliament, Assembly Measures and Assembly Acts enable Welsh Ministers to develop more detailed legislation, known as secondary or subordinate legislation, usually by means of Statutory Instruments (SI). Non-Statutory Instruments (NSI), otherwise known as Ministerial Directions (MD) are legislative in character; they alter legal rights and duties, however they are not SIs. NSIs, which are issued by Welsh Ministers, include codes of practice and guidance. The publication of WHCs can be seen at [Publications | GOV.WALES](#).

For Aneurin Bevan University Health Board, the website is regularly reviewed, by the Corporate Governance Team, for new Ministerial Directions and added to the tracker for review by the respective executive lead.

Asesiad / Assessment

Annual reporting of compliance with WHCs and MDs is included within the Annual Governance Statement. However, to ensure a more robust process to monitor the status of WHCs throughout the year, a WHC and MD Tracker has been established, with progress against the tracker reported to the Audit, Risk and Assurance Committee twice a year.

An overview of progress, as at the end of August 2024, is provided below:

	Welsh Health Circulars		
	2022	2023	2024
No Progress	0	0	3
In Progress	1	9	11
Complete	28	34	15
Withdrawn	1	0	0
Total Number issued	30	43	28

	Ministerial Directions		
	2022	2023	2024
No Progress	0	0	0
In Progress	0	3	0
Complete	13	16	3
Withdrawn	0	0	0
Total Number issued	13	19	3

The full tracker is provided as Appendix One, however, those WHCs and MDs not yet complete are highlighted below:

WHC No	Name of WHC
WHC/2022/022	The role of the Community Dental Service
WHC/2023/001	Eliminating hepatitis (B and C) as a public health threat: actions for 2022 to 2023 and 2023 to 2024
WHC/2023/009	COVID-19 vaccination of children aged 6 months to 4 years in a clinical risk group
WHC/2023/011	Guidance on Self-harm: assessment, management and preventing recurrence
WHC/2023/039	Independent Authorisation of Blood Component Transfusion (IABT)
WHC/2023/040	The NHS Wales: Newborn and Infant Physical Examination Cymru (NIPEC)
WHC/2023/041	Refresh of the rare disease action plan 2022 to 2026
WHC/2023/043	Vaccination of Healthcare Staff to Protect Against Measles
WHC/2023/045	Recording dementia read codes
WHC/2023/047	Influenza vaccines and eligible cohorts for the 2024 to 2025 season
WHC/2024/002	Standards for Competency Assurance of Non-Medical Prescribers in Wales
WHC/2024/006	National Clinical Guidance for Stroke, for the UK and Ireland
WHC/2024/007	Guidelines for managing patients on the suspected cancer pathway
WHC/2024/008	Vaccination against measles - urgent action
WHC/2024/012	Nursing Preceptorship & Restorative Clinical Supervision - A National Position Statement
WHC/2024/014	Introduction of the Office of National Statistics' (ONS) Register of Geographic Codes (RGCs) as a foundational standard for use across NHS Wales Bodies
WHC/2024/016	Healthy Child Wales Programme: for school aged children
WHC/2024/017	Implementation of the Non-pay elements of the 2022-24 Collective Agreement
WHC/2024/024	Implementation on the agreed approach to preventing Violence and Aggression towards NHS staff in Wales
WHC/2024/028	The National Influenza Immunisation Programme 2024-25
WHC/2024/033	The Winter Respiratory Programme 2024/25

WHC/2024/030	Published Weight Management medication pathway
WHC/2024/034	Directions to apply National Framework for Commissioning of Care and Support
WHC/2024/032	Introduction of RSV Vaccination programme

Issue Date	Ministerial Directions
01/04/2023	The Duty of Candour statutory guidance 2023
01/06/2023	The Primary Care (E-Prescribing pilot scheme) Directions 2023
17/07/2023	NHS (General Medical Services contracts) (Wales) Regulations 2023

Following a review of the database, the Executive Committee and Audit, Risk and Assurance Committee requested that deadlines be added to the database. A review of WHCs issued in 2023 has been undertaken and it has been determined that deadlines are not often provided in WHCs, however the information, where available, will be provided for future updates. If a deadline for action is not provided in the WHC, Executive leads are requested to determine an appropriate timescale for completion and this is now included in the database.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to discuss the current position, taking assurance that the Health Board has a system in place to receive, manage and report against Welsh Health Circulars and Ministerial Directions.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**

Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.

Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• Workforce	Choose an item.
• Service Activity & Performance	Choose an item.
• Financial	Choose an item.
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

**Deddf Llesiant
Cenedlaethau'r Dyfodol – 5
ffordd o weithio
Well Being of Future
Generations Act – 5 ways
of working**

<https://futuregenerations.wales/about-us/future-generations-act/>

Not Applicable
Choose an item.

WHC	TOTAL	COMPLETE	IN PROGRESS	NO UPDATE
2023	43	34	9	0
2024	29	15	11	43

MIN DIR	TOTAL	COMPLETE	IN PROGRESS	NO UPDATE
	41	38	3	0

WHC No	Date Issued	Action required by	Review Date		Name of WHC	Summary	Status	Lead Executive (issued to)	Progress	Rating	Link	Date sent to Exec	Last updated	Health circulars: 2024 to 2027 GOV.WALES
WHC/2024/001	10/01/2024				Changes to the way individuals who are at highest risk from Covid-a9 access lateral flow tests	While the GOV.UK site for lateral flow tests and reporting results is closing, people can get tests and report results	Information	Director of Public Health	Implemented as planned. Citizens being advised during antiviral triage on how to obtain tests from local pharmacies. Information also disseminated via ABUHB Social Media channels. Care homes informed of change to access – can still be used to expedite access to antiviral treatment. Local pharmacies participating in scheme supported by PCCS Pharmacy Advisor.	Complete	Changes to getting COVID-19 tests and treatment for people at most risk (WHC/2024/001) GOV.WALES	10/01/2024	10/04/2024	
WHC/2024/002	05/03/2024	30/09/2024	01/04/2026	-18	Standards for Competency Assurance of Non-Medical Prescribers in Wales	Developed by HEIW following a review of the non-medical prescribing policies currently in place in NHS organisations.	Action	Director of Nursing & Director of Therapies	In progress and on track	In Progress		06/03/2024	13/06/2024	
WHC/2024/004	12/02/2024				Assurance of aseptic preparation of medicines in NHS Wales (Sterile preparation of medicine)	Makes clear the accountability and responsibility of health boards in relation to the unlicensed preparation of aseptic	Action	Medical Director		Complete	Sterile preparation of medicine in NHS Wales (WHC/2024/004) [HTML] GOV.WALES	21/02/2024		
WHC/2024/005	01/02/2024				Private obesity surgery and the Welsh NHS	Clarifies the roles and responsibilities of Welsh NHS providers for patients who have undergone bariatric surgical procedures in the private sector.	Compliance	Medical Director	May 2024: Welsh Govt has acknowledged that it is not possible to implement the WHC at this current time. Welsh Govt has arranged a meeting with HB's and subject matter experts to consider ways in which to address the	Complete	Private obesity surgery and the Welsh NHS (WHC/2024/005) GOV.WALES	02/02/2024	03/06/2024	
WHC/2024/006	22/03/2024				National Clinical Guidance for Stroke, for the UK and Ireland	A partial update of the 2016 fifth edition	Action	Therapies	Delegated to Exec Dir Therapies & Health Sciences for operational implementation. Work to be presented to Stroke Delivery Group (5 th June) and then to PQSOC (2 nd July).	In Progress	The national clinical guideline for stroke (WHC/2024/006) GOV.WALES	22/03/2024	16/08/2024	
WHC/2024/007	09/04/2024				Guidelines for managing patients on the suspected cancer pathway	This document provides guidelines relating to the management of patients on a suspected cancer pathway and the reporting of performance against the cancer target.		Medical Director/COO/Nursing/Therapies		In Progress	Suspected cancer pathway: guidelines (WHC/2024/07) GOV.WALES	11/04/2024	med director request 31/05	
WHC/2024/008	02/02/2024	31/07/2024		27	Vaccination against measles - urgent action	Urgent action to mitigate the risk of a measles outbreak in Wales	Action/Compliance	Director of Public Health	Ongoing work to provide vaccination clinics to schools with <90% uptake, clinics planned until end of term, with final push on communications, social media etc. imminent. Ongoing work and issues identified around data validity and rigour. Vaccine outbreak response plan in development, involving EPRR, Health Protection and Vaccine service. Testing pathways and isolation arrangements have been developed and tested during Gwent measles outbreak.	In Progress	Vaccination of children to protect against measles (WHC/2024/008) [HTML] GOV.WALES	05/02/2024	27/08/2024	
WHC/2024/009	08/02/2024				Covid 19 spring booster vaccination programme 2024	The Welsh Government has accepted the latest advice from the Joint Committee on Vaccination and Immunisation (JCVI), which has advised a spring COVID-19 booster vaccination should be offered to our most vulnerable citizens in 2024. The primary aim of the COVID-19 vaccination programme is the prevention of severe COVID-19 disease (hospitalisation and mortality).	Action	Director of Public Health	Blended model of delivery with Primary Care and community pop-up clinics. Commenced on 2nd April in line with WHC and JCVI requirements. All eligible patients have been offered a vaccine current uptake stands at 78.1% not including the members of the population that have opted out; 65.4% including total eligible population - this is 2nd highest uptake amongst Welsh health boards. The use of multiple community pop-up clinics has posed challenging operational for staffing requirements to fulfil the appropriate reg to non-reg ratios and logistically for delivery of vaccine. This model has been reviewed and feedback incorporated into planning for Autumn 2024/25 campaign.	Complete	COVID-19 spring booster 2024 (WHC/2024/009) [HTML] GOV.WALES	20/02/2024	27/08/2024	
WHC/2024/010	27/02/2024				Welsh Sustainability Conference and Awards - New dates	Amendment of date recognising winter pressures and to capitalise on a full financial year or project delivery	Action	Director of Finance		Complete	NHS Welsh Sustainability Conference and Awards: new date (WHC/2024/010) GOV.WALES	27/02/2024		

WHC/2024/011	06/03/2024		01/04/2027		Changes to dietary advice on feeding young children	Changes to Welsh Government dietary advice for young children aged 1 to 5 years following acceptance of recommendations made by the Scientific Advisory Committee on Nutrition (SACN) in its report on 'Feeding young children aged 1 to 5 years'	Action	Director of Public Health	Response from Dietetics This was disseminated across dietetics to the appropriate areas- which included paediatric dietetics. This guidance and practice have therefore been adopted and utilised in providing individual advise to children and families. This guidance has also been included in updated training delivered by Hayley Lavery in the early years settings. Response from Healthy and Sustainable Preschool Coordinators After receiving the Welsh Health Circular we shared with settings, Early Years Teams and umbrella organisations across Gwent. It has been built into the Agored Cymru Food and Nutrition 2 day Training and update sessions for Childcare Settings, delivered by ABUHB Dieticians. We have also shared with settings, the updated Gold Standard Healthy Snack Award criteria from the Dieticians, incorporating the changes. The changes are discussed during setting visits and reminders sent via newsletters and emails. The circular has been sent to Healthy Schools Leads in Gwent. Information is discussed during meetings attended by HSPSS Officers, for example, EYDCP and Network Events.	Complete	Changes to Welsh Government dietary advice for young children (WHC/2024/011) GOV.WALES	18/03/2024	26/06/2024	
WHC/2024/012	19/03/2024	01/07/2024	01/10/2025	49	Nursing Preceptorship & Restorative Clinical Supervision - A National Position Statement		Compliance/ Action	Director of Nursing	Preceptorship programme reviewed and refreshed, will be delivered centrally to ensure standardisation, equity and a prudent approach. Implementation plan for RCS and SBAR in draft format – require Divisional Nurse and then Exec approval. On track with timescales for meeting submission of implementation plan to WG by 1st July. Several actions undertaken within the implementation plan to date.	In Progress	Nursing preceptorship and restorative clinical supervision: position statement (WHC/2024/012) GOV.WALES	19/03/2024	02/07/2024	
WHC/2024/013	11/04/2024				Governance on interim appointments to Executive and Senior Positions	One Wales approach to the key features of employment to support equity and transparency in recruitment, employment and remuneration	Compliance	Director of Workforce & OD	Implemented in current recruitment practices.	Complete		11/04/2024	31-May	
WHC/2024/014	07/05/2024		30/04/2027		Introduction of the Office of National Statistics' (ONS) Register of Geographic Codes (RGCs) as a foundational standard for use across NHS Wales Bodies	WG formally mandating the use of the register of geographic codes across NHS Wales bodies as a strictural standard for coding geohraphic data in all IT and digital systems/services	Compliance	Director of Digital	We are compliant with the use of ONS codes in areas where it is appropriate to use them. There are however some areas where ONS conflicts with codes required for statutory reporting . In these instances, we must comply with NHW Wales data standards until ONS and NHS Wales align coding standards.	In Progress	Introducing ONS geographic codes for use as standard in NHS Wales (WHC/2024/014) [HTML] GOV.WALES	13/05/2024	16/08/2024	

WHC/2024/016	12/04/2024				Healthy Child Wales Programme: for school aged children	A new unified operating model for school nursing services which provides a programme of planned universal health contacts for all compulsory school aged children (5-16) regardless of setting.	Action / Information	Director of Nursing	Launched April 2024. With a 2 year implementation period, with x4 national working streams: Workforce & Training / Monitoring Framework / Performance/ Digital & Data/ Comms & Engagement. (Workstreams commencing July 2024). The operating model includes all children, regardless of the setting, under current workforce position, this HCWP programme is undeliverable and requires significant service investment Local planning / priorities for delivery : Briefing paper / SBAR for Executive Directors on the workforce investment required through the IMTP, Consultation workshops with management and staff in place Profiling the health needs of communities and enhancing the role of skill mix. CPD plan for staff. Scoping `regardless of setting` population needs and the impact on service delivery.	In Progress	Healthy Child Wales Programme: for school aged children (WHC/2024/016) GOV.WALES	12/04/2024	13/06/2024	
WHC/2024/017	28/03/2024	Different dates per section		#VALUE!	Implementation of the Non-pay elements of the 2022-24 Collective Agreement	A control framework for the delivery in partnership of certain non-pay elements of the development of which were aspects of our collective agreement 2022-24	Action	Director of Workforce & OD	First phase response complete 31 st May 2024 and 31st July 2024 as per WHC requirements. WHC to be added as standing agenda item to TUPF from June 24	In Progress	Implementation of the non-pay parts of the 2022 to 2024 collective agreement (WHC/2024/017) [HTML] GOV.WALES	08/04/2024	20-Aug	
WHC/2024/019	17/04/2024		Oct-24		Interim amendments to the Model Standing Orders for Local Health Boards and NHS Trusts in Wales	Interim amendments to the Model Standing Orders for Local Health Boards and NHS Trusts in Wales	Action	Director of Corporate Governance		Complete				
WHC/2024/020	13/05/2024				New Treatment fund: directions on the exemptions for health boards and trusts	What local health boards and NHS trusts must do to make medicines and other interventions available.	Compliance/ Action	Medical Director	The New Treatment Fund commenced in January 2017 and the value of the grant has not increased since then. The money is received annually and distributed immediately and forms part of the core budget of operational divisions. The exemptions set out in the WHC are procedural and have been incorporated in to the standard operating procedures of the Hospital Medicines Group.	Complete	New treatment fund: directions on the exemptions for health boards and trusts (WHC/2024/020) [HTML] GOV.WALES	13/05/2024	03/06/2024	
WHC/2024/022	24/04/2024		Apr-27		Dispute Arbitration Process - Guidance for Disputed Debts (Invoices and service agreements) within NHS Wales: 2024/25-2026/27	This approach aims to continue to increase certainty of NHS Wales contracted income and expenditure assumptions and allow early resolution of issues		Director Of Finance	In place	Complete		20/06/2024		
WHC/2024/024	21/05/2024		N/A		Implementation on the agreed approach to preventing Violence and Aggression towards NHS staff in Wales	To inform organisations of the refreshed 'Obligatory responses to violence in healthcare document' including the requirements to implement and report upon violent incidents as set out in document.	Action	Director of Therapies & Health Sciences	No update	In Progress	Anti-violence collaborative obligatory responses document (WHC/2024/024) GOV.WALES	22/05/2024 changed from WOD to Peter 23/05	07/08/2024	
WHC/2024/025	04/06/2024		Apr-25		NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme for 2024/25	Health boards and trusts in Wales are required to fully participate in all national clinical audits and outcome reviews listed in the annual National Clinical Audit & Outcome Review Annual Plan. This circular provides a copy of the National Clinical Audit and Outcome Review Plan for 2024/25, which shall also be available via the Welsh Government website.	Info/Action	Medical Director	Clinical Audit Outcomes Report form part of the quarterly Quality Report. Mid-year review scheduled for Sept ARA Comm.	Complete	Consultation Template (gov.wales)	20/06/2024		

WHC/2024/026	22/05/2024		Apr-25		2024/25 LHB, SHA & Trust Monthly Financial Monitoring Return Guidance	This guidance refers to the monitoring return spreadsheet and accompanying narrative that all organisations (Local Health Boards (LHBs), Special Health Authorities (SHAs) and Trusts) will need to complete, to report their 2024/25 financial performance. There are a number of changes to the format of the returns from those issued previously.	Compliance	Director of Finance	Compete	Complete	NHS Wales financial monitoring guidance 2024 to 2025 (WHC/2024/026) GOV.WALES	22/05/2024	08/08/2024	
WHC/2024/027	19/06/2024		Until replaced		All Wales Critical Care Escalation Guidance for the Management of Large Unplanned Increases in Demand	Publication of revised All Wales Critical care Escalation Guidance. These guidelines replace all previous versions of escalation and emergency planning guidance for critical care services issued by the Welsh Government.	Information	Director of Strategy, Planning & Partnerships	Guidance only - picked up at Division	Complete	Critical care escalation guidance (WHC/2024/027) GOV.WALES	20/06/2024		
WHC/2024/028	12/06/2024		N/A		The National Influenza Immunisation Programme 2024-25	Revised version of WHC/2023/047 The National Influenza Immunisation programme 2024-25 will once again form part of a single Winter Respiratory Vaccination Programme (WRVP) alongside the COVID-19 autumn vaccination programme. A WRVP Welsh Health Circular will be issued once the JCWI's final advice on the 2024-25 COVID-19 programme is published	Compliance/Action	Director of Public Health	Plans have been submitted to VPW. Locally information has been disseminated to all providers.	In Progress	The national influenza immunisation programme 2024 to 2025 (WHC/2024/028) GOV.WALES	17/06/2024 from Danielle from us 20/06	27/08/2024	
WHC/2024/029	11/06/2024				Certification of Vision Impairment in Primary and Community Care	4 changes to the existing Certification of Vision Impairment Wales (CVIW) form	Compliance	COO	Following completion of relevant HEIW training module, 34 practices are now providing the WGOS 3 service with provision across all 5 boroughs, enabling patients to be certified as visually impaired by WECS optometrists rather than by consultant ophthalmologist. https://www.nhs.wales/sa/eye-care-wales/eye-care-docs/whc-2023-10-certificate-of-visual-impairment-in-primary-and-community-care-pdf/	Complete	Certification of vision impairment in primary and community care (WHC/2024/029) (gov.wales)	20/06/2024		
WHC/2024/030	03/07/2024		01/07/2025		Published weight management medication pathway	An addendum to the 'All Wales weight management pathway' and in response to the National Institute for Health and Care Excellence (NICE)'s approval of new medications for weight management.	Action	Director of Public Health			Published weight management medication pathway (WHC/2024/030) [HTML] GOV.WALES	28/08/2024		
WHC/2024/031	17/06/2024		N/A		Agency workforce reduction programme and control framework 2024 to 2025	Coordinating action to reduce agency workforce expenditure in Wales	Action	Director of Workforce & OD	Actioned - Variable Pay Programme Board TOR updated in line with WHC	Complete	Agency workforce reduction programme and control framework 2024 to 2025 (WHC/2024/031) [HTML] GOV.WALES			
WHC/2024/032	25/06/2024				Introduction of RSV Vaccination programme	New routine RSV vaccination programme from September 2024 to protect both infants and older adults	Action	Director of Public Health			Introduction of RSV vaccination programme 2024 (WHC/2024/032) [HTML] GOV.WALES	28/08/2024		
WHC/2024/033	02/08/2024				The Winter Respiratory Programme 2024/25	To set out the detail of the Winter Respiratory Vaccination Programme (WRVP) 2024/25 and our expectations for the coming season.	Compliance/Action	Director of Public Health	Plans have been submitted to VPW. Noted change to eligibility and offer to health and social care staff for COVID-19. Wider commissioning options reviewed, community pharmacies invited (4 pharmacies currently signed up)	In Progress	Winter respiratory vaccination programme 2024 to 2025 (WHC/2024/033) GOV.WALES	02/08/2024	27/08/2024	
WHC/2024/034	28/08/2024	01/09/2024		4	Directions to apply the national Framework for the Commissioning of Care and Support in Wales: Code of Practice to local health boards and NHS Trusts - August 2024	Legislation to be complied with re the Commissioning of Care Support in Wales	Compliance				National framework for commissioning care and support (WHC/2024/0234) GOV.WALES	28/08/2024 by DJ		

WHC No	Date Issued	Action required by (if applicable)	Review Date	Name of WHC	Summary	Status	Lead Executive (issued to)	Progress	Rating	Link
WHC/2023/001	16/01/2023			Eliminating hepatitis (B and C) as a public health threat: actions for 2022 to 2023 and 2023 to 2024	Letter to health boards on the actions they need to take to make progress on hepatitis B and C elimination	Action	Director of Public Health	Multi-agency steering group established, baseline position in place, and reviewing priorities to inform joint recovery plan. JRP submission date extended by WG to mid-July. Joint Recovery Plan submitted in July 2023. Positive feedback received on the plan from WG Oversight Group in March 2024. Implementation of Joint Recovery Plan underway through cross-divisional and multi-agency Implementation Group that reports to Public Health Protection Programme Board. Update on progress for 23/24 actions for submission to WG Oversight Group by 31 March 24 with 24/25 plan for submission to WG Oversight Group by 31 May 24. There is ongoing commitment to the delivery of the JRP through collaborative working across the Health Board, Area Planning Board, drug and alcohol services, community pharmacies and criminal justice partners. Particularly during this phase; in increasing testing within high risk groups through increased outreach clinics, community health events where BBV testing is available, testing for people in contact with the criminal justice system through probation testing events, and in-reach BBV testing through Community Pharmacies in Gwent. Preparations have commenced for objectives outlined in the next phase of the JRP	In progress	Eliminating hepatitis (B and C) as a public health threat: actions for 2022 to 2023 and 2023 to 2024 (WHC/2023/001) GOV.WALES
WHC/2023/002	31/01/2023		N/A	Faecal immunochemical testing (FIT) in symptomatic colorectal cancer referral	Letter to health boards on faecal immunochemical testing (FIT) for suspected bowel cancer (new guidance/thresholds)	Action	Medical Director	This was actioned within AB before the WHC circulation and discussed at cancer Board on the 18th January	complete	https://www.gov.wales/sites/default/files/publications/2023-01/new-lower-gastrointestinal-fit-national-optimal-pathway.pdf
WHC/2023/003	04/04/2023		01/05/2025	Guideline for the Investigation of Moderate or Severe early developmental impairment or intellectual disability (EDI/ID) (ED/ID)	clinical guideline for the investigation of moderate or severe early developmental impairment or intellectual disability (EDI/ID)	Action	Medical Director	Completed This has been disseminated to all Paediatric medical staff (community and general, consultants, trainees, ANPs and Specialty Doctors)	Complete	https://www.gov.wales/sites/default/files/pdf-versions/2023/4/3/1681288392/early-
WHC/2023/004	08/03/2023		N/A	COVID-19 spring booster 2023	Provision of additional spring COVID-19 booster dose for our most vulnerable citizens.	Action	Director of Public Health	Implemented as required and on target for delivery as and uptake as planned	Complete	https://www.gov.wales/sites/default/files/publications/2023-03/whc202304-covid-19-spring-booster-2023-english_0.pdf
WHC/2023/006	31/03/2023		01/04/2024	Commencement of the Health and Social Care (Quality and Engagement) (Wales) Act 2020	guidance on the commencement of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 on 1 April 2023.	Action	Director of Nursing Medical Director Director of Therapies and Health Science	Quality Strategy and Patient Experience and Involvement Strategy approved and implementation underway. Training session held for Board members. Also issued to Director of Nursing & Director of Therapies and Health Science	Complete	https://www.gov.wales/sites/default/files/publications/2023-04/commencement-of-the-health-and-social-care-quality-and-engagement-wales-act-2020_0.pdf
WHC/2023/007	31/03/2023		01/06/2023	Patient testing framework, updated guidance	Updated guidance April to September 2023	Action	Director of Public Health	Implemented and interpreted locally. On-going discussions in place with PHW regarding support from AWARE in relation to care home testing.	complete	https://www.gov.wales/sites/default/files/publications/2023-03/patient-testing-framework-updated-guidance.pdf
WHC/2023/008	25/09/2023	18/09/2023	18/09/2023	SaBTO FAIR III recommendations to tissue and cell donation process	Implementation of the recommendations outlined in the FAIR III report for any living or deceased tissue or cell donations	Action/Information	Medical Director	The tissue donation consent process is handled by NHSBT. The referral forms used by ABUHB do not ask any questions relating to consent that are impacted by the FAIR III recommendations. The ABUHB forms are predominantly an initial screening referral tool that then allows NHSBT to contact patient's families and proceed with the formal consent process.	Complete	Advice on tissue and cell donation (WHC/2023/008) GOV.WALES
WHC/2023/009	06/04/2023		N/A	COVID-19 vaccination of children aged 6 months to 4 years in a clinical risk group	The Welsh Government has accepted the latest advice from the Joint Committee on Vaccination and Immunisation (JCVI), which recommended the vaccination for COVID 19 of children aged 6 months to 4 years in a clinical risk group. Health Boards will start to invite eligible children for vaccination in	Action	Director of Public Health	Implemented as required, and incorporated into all COVID vaccination campaign planning/programmes.	in progress	https://www.gov.wales/sites/default/files/publications/2023-04/covid-19-vaccination-of-children-aged-6-months-to-4-years-in-a-clinical-risk-group-whc202309.pdf

WHC/2023/011	27/04/2023		Apr-28	Guidance on Self-harm: assessment, management and preventing recurrence	NICE guidance	Information	Chief Operating Officer	All GP practices in ABUHB made aware of the NICE guidance. The key recommendations associated with safeguarding, consent and confidentiality are part of the wider contractual Clinical Governance Toolkit and revalidation requirements of practitioners. All departments within MH&LD are aware of the NICE Guidelines, with information distributed for awareness through different methods within each department. - Within Primary Care Mental Health Support Services, registrants have conversations about risk with people referred as part of the 'Brief Review of Your Needs' BRYN conversation and use the CORE 10 (an evidence-based therapy tool) to inform conversations about risk & safety if a full assessment is required; CORE 10 is also used as an outcome measure. Along with use of MIND and Melo, there is evidence that this support is used regularly. - Within Secondary Care Mental Health services, the Wales Applied Risk Research Network (WARRN) is used as the primary risk formulation tool, which is also evidence based. - Additionally, within Adult Mental Health Crisis services, the Health Board has worked with Improvement Cymru as part of a national piece of work to pilot Person Centred Safety Planning in services. Colleagues across the Division are invited to attend awareness training sessions based on the findings of the annual National Confidential Inquiry into Suicide and Safety in Mental Health, to inform risk formulation and management. - Several of the liaison and CRHTs are now trained in DBT skills and CBT along with having access to multi-disciplinary peer supervision for repeat attendees to allow a formulation and reconsideration of	in progress	Guidance on Self-harm (WHC/2023/11) GOV.WALES
WHC/2023/012	02/05/2023		Apr-24	NHS Wales financial monitoring returns, 2023 to 2024	Monthly financial monitoring return guidance and associated templates	Action	Director of Finance and Procurement		Complete	NHS Wales financial monitoring returns, 2023 to 2024 (WHC/2023/012) GOV.WALES
WHC/2023/013	17/05/2023		2028	Health and Care Quality Standards 2023	Replacing Health and Care Standards - WHC/2015/015	Action	Director of Nursing		Complete	Health and Care Quality Standards 2023 (WHC/2023/013) GOV.WALES
WHC/2023/015	09/05/2023		N/A	COVID-19 Vaccination observation periods	A letter to health workers regarding COVID-19 vaccinations	Action	Director of Public Health	Information cascaded and SOPs updated	Complete	https://www.gov.wales/sites/default/files/publications/2023-05/covid-19-vaccination-observation-periods-vaccination-following-recovery-from-covid-19.pdf
WHC/2023/016	12/05/2023		N/A	Implementing the move to one dose of the HPV vaccine in Wales	Letter to health professionals confirming changes to the HPV vaccination programme	Action	Director of Public Health	School based Programme: ABUHB School Nursing Service acyioned the requirements of WHC/2023/016 'Implementing the move to one dose of the HPV vaccine in Wales', the changes are included in our HPV Comms & Engagement plans 23/24. Professionals: ABUHB School Nursing staff updates provided through our training events/updates through school our learning zone/emails/borough meetings. Schools have been updated through our communication when planning the schools sessions. Public: ABUHB School Nursing service prepared parents/carers of the pending changes in our literarture sent for HPV in 22/23. We will be utilising the PHW updated literature for our HPV programme and updating our consent forms. We are launching HPV in the spring term and have prepared social media and comms messaging to share on all our social media platforms. We have developed new training	Complete	https://www.gov.wales/sites/default/files/publications/2023-05/hpv-immunisation-programme-update.pdf

WHC/2023/017	12/05/2023		31/03/2024	NHS Wales Executive National Policy on Patient Safety Incident Reporting and Management	A policy for the NHS in Wales to report, manage and learn from patient safety incidents.	Action	Director of Nursing	12/4/23: The publication of the RDAP has been highlighted and shared with clinical leads across several specialities. Work is ongoing to ensure ABUHB adheres to the four key priorities outlined in the plan.	Complete	https://www.gov.wales/sites/default/files/publications/2023-05/policy-on-patient-safety-incident-reporting-and-management.pdf
WHC/2023/018	14/06/2023		Jun-26	Introduction of HL7 FHIR as a foundational standard in all NHS Wales Bodies	Mandating FHIR as a foundational interoperability standard for all IT and all digital systems/services	Action	Director of Digital	Confirmed we have adopted HL7 / FHIR as a foundational standard and are working closely with the National Data Resource Programme on development of our local capabilities.	Complete	Introduction of HL7 FHIR as a foundational standard in all NHS Wales Bodies (WHC/2023/018) GOV.WALES
WHC/2023/019	09/06/2023	Immediate		In support of prevention of suicide and self harm: GMC and NICE Guidance on Information disclosure for the protection of patients and others	GMC and NICE Guidance on information disclosure for the protection of patients and others	Information	Medical Director	This was issued via the All Wales Alert system on 9th June 2023 and cascaded to: GP Practice Managers, GP OOHs, Sessional GPs, HB Primary Care Managers, Medial Committees, Independent Hospitals / ~~Universities / Prisons~~	Complete	In support of prevention of suicide and self-harm (WHC/2023/019) GOV.WALES
WHC/2023/021	08/08/2023		08/08/2028	Consent to Examination or Treatment - Update	Replaces WHC/2017/036 - retired with immediate effect	Action	Medical Director	Completed: WHC and relevant information to consent is available on HB intranet / SharePoint. The Consent Policy being updated to reflect up to date information. Newsletter issued bringing together up to date information on consent in one place. Poster also created and distributed. Audits being undertaken to provide assurance e-learning module on Decision Making and Consent in Wales.	Complete	Consent for examination or treatment: update (WHC/2023/021) GOV.WALES
WHC/2023/022	22/06/2023		30/06/2026	Armed Forces Covenant - Healthcare Priority/Special Consideration for Veterans/ Ex Armed Forces Personnel	Update and clarify guidance on Armed Forces Covenant - Healthcare Priority for Veterans (WHC (2017) 41	Action	Director of Workforce & OD	Action plan in place to implement the requirements of the WHC	Complete	Armed Forces Covenant healthcare priorities (WHC/2023/022) GOV.WALES
WHC/2023/023	22/06/2023			The National Influenza Immunisation Programme 2023-24	Detailed guidance for the flu vaccination programme 2023-24	Action/Information	Director of Public Health	Information cascaded and delivery plans adjusted accordingly. GPs advised through local and national communication lines	complete	The National Influenza Immunisation Programme 2023 to 24 (WHC/2023/023) GOV.WALES
WHC/2023/024	28/06/2023			Change of vaccine and cohort expansion for shingles vaccination programme (From September 2023)	Information about forthcoming changes to the NHS Wales shingles vaccine programme	Compliance/Action/Information	Director of Public Health	Proposed changes to the shingles programme included in our annual update training since June 23. This is delivered to Practice Nurses, HCSW and District Nurses. Cascaded all correspondence from PHW to practices, including training resources, PGD's etc. Scoped all GP practices for their implementation plans. Encouraged practices to prioritise the 50+ years, immunocompromised. Discussions held re the possibility of running shingles clinic in covid-19 vaccine centres (resource permitting)	Complete	Changes to shingles vaccinations (from September 2023) (WHC/2023/024) GOV.WALES
WHC/2023/025				Cancer Waiting Times Rules for SCP				13/4/23: LT Message sent to all practices on 6/5/22 . This theme is also included in the work programme for the medicines management team for this coming year.	Complete	Suspected cancer pathway: guidelines (WHC/2023/025) GOV.WALES

WHC/2023/026				NHS FRAMEWORK FOR RESEARCH AND DEVELOPMENT – Research Matters – What excellence looks like in NHS Wales	Introduction of the new Research and Development (R&D) Framework, in a drive to embed and integrate research into all aspects of health and care services in NHS Wales	Action	Medical Director	Complete: The ABUHB R&D strategy was developed in consultation with HCRW and fully supported and approved by the Board in November 2022 which shows that research is not seen as an additional activity but is a core function. Developing an implementation plan as included a series of stakeholder events including patients and public, the purpose being to map and explore our stake holders expectations. This has helped define clear focus areas and timelines for implementation and adds value to the service we provide. Collaboration with our partners and stakeholders is key to its success and we are committed to ensuring that we nurture those who display early talent to become strong research leaders. The first year has included engagement within the wider organisation to raise awareness of the strategy and our vision, as well as putting foundations in place to support implementation. The next steps are to defining work streams, delegating leads for projects and ensuring we can measure progress. Progress and performance monitoring will ensure we can regularly update, review and revise our implementation plan.	Complete	NHS framework for research and development (WHC/2023/026) GOV.WALES
WHC/2023/028				Withdrawal of WHC 2019/042 re Annual Quality Statements	Removing the requirement to prepare Annual Quality Statements as a result of the revised reporting arrangements introduced under the Duty of Quality	Action	Director of Nursing	Noted	Complete	Withdrawal of WHC/2019/042 regarding annual quality statements GOV.WALES
WHC/2023/029	21/08/2023			Winter Respiratory Vaccination Programme: Autumn and Winter 2023 to 2024	Details of the next winter vaccination program	Action	Director of Public Health	Information cascaded and delivery plans adjusted accordingly. GPs advised through local and national communication lines	Complete	Winter respiratory vaccination programme 2023 to 2024 (WHC/2023/029) GOV.WALES
WHC/2023/031			31/03/2024	AMR & HCAI Improvement Goals for 2023-24	Continuing to work towards the goals of the current 5 year National Action Plan.	Action	Director of Nursing		Complete	Consultation Template (gov.wales)
WHC/2023/032	09/10/2023		Mar-24	Amendments to Model Standing Orders and Model Standing Financial Instructions	Supercedes WHC/2020/011 & WHC/2021/010	Compliance/Action	Director of Corporate Governance	Tissue donation discussed at each Organ Donation Committee. Report on progress from	Complete	Amendments to Model Standing Orders and Model Standing Financial Instructions – NHS Wales (WHC/2023/032) GOV.WALES
WHC/2023/033				Vaccine Products to be used in the Autumn 2023 covid-19 Vaccination Programme	Further COVID-19 vaccine information following WHC/2023/029	Compliance/Action	Director of Public Health	Information cascaded SOP's & delivery plans updated	Complete	WN (Year) Number (gov.wales)
WHC/2023/034	25/09/2023			NHS Welsh Sustainability Awards	Information regarding NHS Welsh Sustainability Conference and awards	Action	Director of Finance		complete	NHS Welsh Sustainability Conference and Awards (WHC/2023/034) GOV.WALES
WHC/2023/035	03/11/2023		Oct-26	Update of guidance on clearance and management of healthcare workers living with a bloodborne virus (BBV) and a reminder of health clearance for	Update to WHC/2019/023 issued in July 2019	Action	Director of Workforce & OD	Actioned	Complete	Health workers with bloodborne viruses (BBV), and TB clearance (WHC/2023/035) GOV.WALES
WHC/2023/036	20/09/2023			Speaking up Safely Framework - NHS Wales	Publication of the Framework for Speaking up Safely in NHS Wales	Action	Director of Workforce & OD	Published on the Health Board's Intranet Site	Complete	NHS Wales speaking up safely framework (WHC/2023/036) GOV.WALES
WHC/2023/037	26/09/2023		31/12/2023	Patient Testing Framework for Autumn/Winter 23	Update to WHC issued in March 2023	Action	Director of Public Health	The Patient Testing Framework for Autumn/Winter 2023 was received and discussed within the appropriate Leadership meeting. This concluded that no further action was required within the existing sampling provision (ABUHB Health Protection Service) or within pathology. The updated framework was cascaded to the wider Health Board the senior Leadership Team via emails and the use of the staff Intranet, in conjunction with IPAC's updated staff risk assessment. Additionally, a local collaborative Winter Pressures plan has been developed to ensure that a robust approach is available should demand increase over the winter period. Samples Undertaken: Sept - 18 October - 40	Complete	Patient testing framework for autumn/winter 2023 (WHC/2023/037) GOV.WALES
WHC/2023/038	09/11/2023	Immediate effect		Healthy Start eLearning Course	Bite size training course for health professionals to raise awareness of Healthy Start Scheme	Action	Director of Workforce & OD	Course live on ESR	Complete	Healthy Start eLearning course (WHC/2023/038) GOV.WALES

WHC/2023/039	Nov-23		30/10/2026	Independent Authorisation of Blood Component Transfusion (IABT)	Policy to equip appropriate health care professionals who are not medical practitioners for the role of blood component transfusion.	Action/Information	Medical Director	The WHC has been discussed by the HB Hospital Transfusion Committee (HTC). The HB current policy and standard operating procedures for prescribing blood are to be reviewed in light of the WHC. The Health Board employs several non-medic BCT Authorisers who have undertaken the appropriate Wales training and compliance assessment. Each BCT Authoriser has a Consultant mentor, retains a	In progress	Independent authorisation of blood component transfusion (IABT) - 2023 to 2026 (WHC/2023/039) GOV.WALES

Ministerial Directive	Date Issued	Summary	Lead Executive	Action to demonstrate implementation/response	Rating	Link	Date sent to exec	Updated	Publications GOV.WALES
The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) Directions 2022	07/04/2022	Amendments to Directions to reflect new activity measures for contract reform practices.	Interim Director Primary, Community and Mental Health Services	Implemented	Complete	https://www.gov.wales/sites/default/files/publications/2022-04/the-directions-to-local-health-boards-as-to-the-personal-dental-services-statement-of-financial-entitlements-amendment-directions-2022_0.pdf			
The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) Directions 2022	07/04/2022	Amendments to Directions to reflect new activity measures for contract reform practices.	Interim Director Primary, Community and Mental Health Services	Implemented	Complete	https://www.gov.wales/sites/default/files/publications/2022-04/the-directions-to-local-health-boards-as-to-the-general-dental-services-statement-of-financial-entitlements-amendment-directions-2022_0.pdf			
Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2022	09/06/2022	Directions to local health boards on amendments to the general medical services contract	Interim Director Primary, Community and Mental Health Services	Implemented	Complete	https://www.gov.wales/sites/default/files/publications/2022-06/directions-to-local-health-boards-as-to-the-statement-of-financial-entitlements-amendment-no-2-directions-2022.pdf			
The National Health Service (Charges to Overseas Visitors) (Amendment) (No. 3) (Wales) Regulations 2022	29/06/2022	These Regulations amend the National Health Service (Charges to Overseas Visitors) Regulations 1989 (S.I. 1989/306).	Director of Finance and Procurement	Regulation has been implemented. Monkeypox has been added to the 'non chargeable' category of diseases.	complete	https://www.gov.wales/sites/default/files/publications/2023-01/the-national-health-service-charges-to-overseas-visitors-amendment-no-3-wales-regulations-2022.pdf			
The Pharmaceutical Services (Advanced Services) (Appliances) (Wales) (Amendment) Directions 2022	29/07/2022	The Directions set out amendments to the requirements for the provision of appliance services in Wales	Medical Director	The amendments are published in the drug tariff and are publicly available. In this instance the directions aren't tasking the HB to action anything as it's an update of existing arrangements, so there's nothing to disseminate. Additionally, although we maintain provision for pharmacies or appliance contractors to commission stoma appliance customisation and Appliance Use Reviews (covered in our PNA) the HB doesn't have any pharmacies providing the service or any appliance	complete	https://www.gov.wales/sites/default/files/publications/2022-07/the-pharmaceutical-services-advanced-services-appliances-wales-amendment-directions.pdf			
The Primary Medical Services (Influenza and Pneumococcal Immunisation Scheme) (Directed Enhanced Service) (Wales) (No. 2)	08/08/2022	The amendment Directions update the clinically at risk groups eligible for the influenza vaccination	Interim Director Primary, Community and Mental Health Services	Implemented	Complete	https://www.gov.wales/sites/default/files/publications/2022-08/the-primary-medical-services-influenza-and-pneumococcal-immunisation-scheme-directed-enhanced-service-wales-no.-2-amendment-directions-2022.pdf			
The Primary Care (Contracted Services: Outpatient Waiting List Scheme) Directions 2022	12/08/2022	Directions and guidance for Local Health Boards on reviewing outpatient waiting lists.	Interim Director Primary, Community and Mental Health Services	Lead with Planned Care Board. Practices asked if they wish to participate - no further action taken at this time	Complete	https://www.gov.wales/sites/default/files/publications/2022-08/the-primary-care-contracted-services-outpatient-waiting-list-scheme-directions-2022.pdf			
Primary Care Contracted Services: Immunisations (PCCS:I) Amending Directions August 2022	25/08/2022	How health boards can engage primary care contractors to administer the COVID-19 vaccine.	Interim Director Primary, Community and Mental Health Services	Implemented	Complete	https://www.gov.wales/sites/default/files/publications/2022-08/primary-care-contracted-services-immunisations-2-directions-20-22.pdf			
The Abortion Act 1967 – Revocation of the Approval of a Class of Place for Treatment for the Termination of Pregnancy (Wales) 2022	26/08/2022	Provisions within the Health and Care Act 2022 come into force on 30 August 2022. Therefore, the Approval of a Class of Place for Treatment for the Termination of Pregnancy (Wales) 2022 is revoked to ensure there is no overlap in legislation.	Medical Director	The HB already allow patients to administer medications to induce a legal abortion in their own home. The medications will have been prescribed by a hospital based doctor after completing the appropriate 'blue form'	complete	https://www.gov.wales/sites/default/files/publications/2022-08/the-abortion-act-1967--revocation-of-the-approval-of-a-class-of-place-for-treatment-for-the-termination-of-pregnancy-wales-2022.pdf			
The National Health Service (Charges to Overseas Visitors) (Amendment) (No. 4) (Wales) Regulations 2022	22/11/2022	The Regulations add Malta and the Bailiwick of Guernsey to the list of countries with which the UK has a reciprocal healthcare agreement.	Director of Finance and Procurement	Regulation has been implemented. Guernsey and Malta have been added to the list of countries where the Health Board has reciprocal arrangements.	complete	https://www.gov.wales/sites/default/files/publications/2023-01/the-national-health-service-charges-to-overseas-visitors-amendment-no-4-wales-regulations-2022.pdf			
The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2022	30/11/2022	Fee scales for dispensing doctors from 1 October 2022 to 31 March 2023 and from 1 April 2023	Director of Finance and Procurement	This regulation has been implemented as required - by NWSSP.	complete	https://www.gov.wales/sites/default/files/publications/2022-11/directions-to-local-health-boards-as-to-the-statement-of-financial-entitlements-amendment-no-4-directions-2022.pdf			
The Wales Infected Blood Support Scheme (Amendment) (No. 2) Directions 2022	08/12/2022	Wales Infected Blood Support Scheme introduction of child payments.	Director of Finance and Procurement	Ministerial Direction implemented by NWSSP on behalf of Wales Infected Blood Support Scheme (WIBSS) - WIBSS has written to all current beneficiaries of WIBSS to bring this to their attention and also included a reference in the December 2022 Newsletter. As at 31 March 2023 18 applications had been processed in respect of 31 children; amounting to a commitment of £69,600	Complete	https://www.gov.wales/sites/default/files/publications/2022-12/the-wales-infected-blood-support-scheme-amendment-no-2-directions-2022.pdf			
The Local Health Boards (Directed Functions) (Wales) Directions 2022	15/12/2022	Directions to local health boards relating to prisoner healthcare in 'His Majesty's Prison and Young Offender Institute Parc'.	Interim Director Primary, Community and Mental Health Services	Implemented	Complete	https://www.gov.wales/sites/default/files/publications/2022-12/the-local-health-boards-directed-functions-wales-directions-2022.pdf			
The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) Directions 2023	13/01/2023	These Directions uplift NHS dental contract payments for 2022 to 2023.	Interim Director Primary, Community and Mental Health Services	Implemented	Complete	https://www.gov.wales/sites/default/files/publications/2023-01/the-directions-to-local-health-boards-as-to-the-general-dental-services-statement-of-financial-entitlements-amendment-directions-2023.pdf			
The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) Directions 2023	13/01/2023	These Directions uplift NHS dental contract payments for 2022 to 2023.	Interim Director Primary, Community and Mental Health Services	Implemented	Complete	https://www.gov.wales/sites/default/files/publications/2023-01/the-directions-to-local-health-boards-as-to-the-personal-dental-services-statement-of-financial-entitlements-amendment-directions-2023.pdf			

Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2023	21/02/2023	Directions to local health boards on amendments to the general medical services contract.	Interim Director Primary, Community and Mental Health Services	Implemented	Complete	https://www.gov.wales/sites/default/files/publications/2023-02/directions-to-local-health-boards-as-to-the-statement-of-financial-entitlements-amendment-directions-2023.pdf			
Local health boards and NHS Trusts reporting on the introduction of new medicines into the National Health Service in Wales Directions 2023	24/03/2023	Directions regarding the Implementation of the high-cost drugs reporting system	Director of Finance and Procurement / Medical Director	Implemented	Complete	https://www.gov.wales/sites/default/files/publications/2023-03/local-health-boards-and-nhs-trusts-reporting-on-the-introduction-of-new-medicines-into-the-national-health-service-in-wales-directions-2023.pdf			
The Duty of Candour statutory guidance 2023	01/04/2023	Statutory guidance regarding the purpose and application of duty of candour	Director of Nursing	Currently implementing this guidance as part of the delivery of the Health Board Strategy	In Progress	The Duty of Candour statutory guidance 2023 GOV.WALES		21/03/2024	
The NHS (General Medical Services Contracts) (Wales) Regulations 2023: integrated impact assessment	11/05/2023	WG plans to maintain and improve effective delivery of General Medical Services	Chief Operating Officer	The Unified Contract came into effect on 1 st October 2023. Health Boards are currently awaiting WG to issue a template variation notice and GMS regulations template: • A template variation notice containing the changes needed for a GMS contract that was based on the 2006 template GMS contract to comply with the new regulations, and • A template document from which Health Boards will prepare a “conformed copy” showing, for ease of reference, what your contract looks like after the variations. Once received, these will be personalised and sent to each GP practice. Further details are also expected in relation to the Unified Contract Assurance Framework.	Complete	The NHS (General Medical Services Contracts) (Wales) Regulations 2023: integrated impact assessment GOV.WALES			
The Primary Care (E-Prescribing pilot scheme) Directions 2023	01/06/2023	Arrangements and provisions for E- Prescribing pilot scheme	Director of Digital	The first use of the Electronic Prescription Service (EPS) in Wales is on track to take place this autumn in Rhyl, North Wales. There will be several weeks of testing in Rhyl before EPS is rolled out across Wales in a phased approach in 2024. ABHB will support this as required alongside the Digital Medicines Transformation Portfolio. The Primary Care Electronic Prescription Service (EPS) went live in the first GP practice in Gwent (Llanbradach) in May 2024. The next GP practice to go live is in Blaenavon, targeted in October 2024. ABUHB attends a national EPS advisory group which seeks to agree the ongoing implementation plan across Gwent. Dispensing suppliers, including EMIS, are undergoing national assurance activities and is a dependency on future roll out plans. Implementation timescales at each practice takes between 12 to 16 weeks. A full roll out plan, dependent on GP uptake, is under development.	In Progress	The Primary Care (E-Prescribing Pilot Scheme) Directions 2023 GOV.WALES		16/08/2024	
NHS (General Medical Services contracts) (Wales) Regulations 2023	17/07/2023	Summary report to the informal consultation on th NHS (General Medical Services Contract)(Wales) Regulations 2023	Medical Director	Health Boards received the conformed copy and CVN relating to the 2006 contract on 10th December 2023. Meeting held 6th February 2024 with HBs, WG and Legal representatives to discuss. Identified that not all contracts had received a CVNs in 2006, therefore WG/Legal agreed to provide the necessary documents for this. The HB received the following documents on 7th March 2024 from WG: • A unilateral variation for use with GMS contracts based on the 2004 GMS model contracts that have not been updated by the 2006 national GMS variation. • A unilateral variation for use with either: 2004-based GMS contracts that have been updated by the 2006 national GMS variation, or GMS contracts based on the 2006 GMS model contract. • Conformed copy contract with additional changes to enable it to be used for 2004-based contracts (whether updated by the 2006 national variation or not). • Bilateral variation and template GMS contract. • A Variation Options Flowchart to assist LHBs in which route to take for varying the contracts. This is a significant undertaking, as all contracts have to be reviewed on an individual basis, checking each clause against the CVN and conformed copy. The HB will be issuing bilateral agreements for all contracts, which also requires a 14 day notification period. All contracts must be issued by 18th March to meet this deadline. 20 x bilateral agreements/conformed copy have been	In Progress	NHS (General Medical Services contracts) (Wales) Regulations 2023 GOV.WALES		16/08/2024	
The Primary Medical Services (Influenza and Pneumococcal Immunisation Scheme)(Directed Enhanced Service)(Wales)(No. 2)(Amendment) Directions 2023	28/07/2023	The amendment Directions update the clinically at risk groups eligible for the influenza vaccination	Director of Public Health	This amendment was cascaded and delivery plans adjusted accordingly. GPs advised of change in policy through local and national communication lines	Complete	The Primary Medical Services (Influenza and Pneumococcal Immunisation Scheme) (Directed Enhanced Service) Wales) (No. 2) (Amendment) Directions 2023 GOV.WALES			
The Nursery Milk Scheme (Wales)(Amendment) Directions 2023	31/07/2023	Amendment	Director of Nursing	This is an extension entitlement of the distribution of milk to nurseries for a further 2 years. This offer will be reviewed in two years	Complete	The Nursery Milk Scheme (Wales) (Amendment) Directions 2023 GOV.WALES			

The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2023	07/08/2023	Directions to local health boards on amendments to the general medical services contract.	Director of Finance and Procurement	Enacted by Shared Services automatically	Complete	The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2023 GOV.WALES			
Primary Care Contracted Services: Immunisations (PCCS:I) Amending Directions	24/08/2023	How health boards can engage primary care contractors to administer the COVID-19 vaccine.	Chief Operating Officer	The Primary Care (Contracted Services: Immunisations) scheme has been offered to all GP practices - 33/68 are participating and 1 pharmacy	Complete	Primary Care Contracted Services: Immunisations (PCCS:I) Amending Directions GOV.WALES			
Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment)(No.2) Directions 2023	30/08/2023	Directions to local health boards on amendments to the general medical services contract.	Director of Finance and Procurement	Enacted by Shared Services automatically	Complete	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2023 GOV.WALES			
The National Health Service (Wales Eye Care services)(Wales) Directions 2023	26/10/2023	Shows the amendments to the Low Vision Service Committee (Wales) Directions 2016 and the Eye Health Examination Services Committee (Wales) Directions 2016	COO	Implemented and payments reflected WGOS 1 – previously GOS WGOS 2 – previously EHEW WGOS 1 and 2 are mandatory from 20th October 2023 WGOS 3 – now Low Vision Services Wales (LVSW) and Certified Visual Impairment (CVI)	Complete	The National Health Service (Wales Eye Care Services) (Wales) Directions 2023 GOV.WALES			
The Low Vision Service Committee (Wales) Directions 2016 (with consolidated amendments)	26/10/2023	Shows the amendments made to the Eye Health Examination Service Committee (Wales) Directions 2016 by the National Health Service (Wales Eye Care Services)(Wales) Directions 2023	COO	Implemented and payments reflected WGOS 3 – now Low Vision Services Wales (LVSW) and Certified Visual Impairment (CVI)	Complete	SI/SR Template (gov.wales)			
The Eye Health Examination Service Committee (Wales) Directions 2016 (with consolidated amendments)	26/10/2023	Shows the amendments to the Low Vision Service Committee (Wales) Directions 2016 and the Eye Health Examination Services Committee (Wales) Directions 2016	COO	Implemented process in place with Finance colleagues	Complete	SI/SR Template (gov.wales)			
Statement of general ophthalmic service remuneration and fee Directions.	24/11/2023	The remuneration to be paid and directions to those providing general ophthalmic services and those providing eye examination services under the National Health Service (Ophthalmic Services) (Wales) Regulations 2023 and other fees payable to those providing these services.	COO	Implemented with relevant fees applied. Indicative budget allocation will need continuous review to ensure appropriate level of funding is available for each service. Some services to be implemented.	Complete	Statement of general ophthalmic services remuneration and fee Directions GOV.WALES	30/11/2023	18/03/2024	
Death Certification reform	14/12/2023	Comments requested on the draft regulations relating to medical certification of cause of death and the role of medical examiners. Comments required by 12/01/2024	Medical Director	Issued	Complete	Death certification reform GOV.WALES			
The Medical Examiners (Wales) Regulations 2024	14/12/2023	Draft functions, terms and conditions or employment for medical examiners in Wales.	Medical Director	Primarily affects the function of the Medical Examiner; the HB is considered a stakeholder. As a stakeholder the Mortality Review Process grew significantly within the Health Board during 2023. At the beginning of 2023 the Medical Examiner (ME) Service was confined to scrutinising specific areas at ABUHB. In April 2023, ME coverage expanded to include all acute deaths at all hospital sites. The only acute demographics which remain an exception to this are: Maternity, Paediatrics, & Neonatal Within secondary care a screening and direction process is in place with all ME referral letters (ME reports) are received to a generic email address. Cases are discussed at the ABUHB Mortality Review Screening Panel. Mortality Review Guidance finalised and Strategic Programme for Primary Care to disseminate. Webinars set up for primary care. A work plan is in place to develop the Mortality module of Datix to allow for improved reporting, expansion of the ME service in the HB and to strengthen links between the mortality reviews, PAL and the CAD services. NWSSP ME Service provide all certifying drs with a guide and podcast as well as sign posting to learning, especially primary care. Welsh Govt plans to handle the communications processes. The HB has linked with practices to ensure ME have access to the medical record.	Complete	The Medical Examiners (Wales) Regulations 2024 GOV.WALES			
The Eye Health Examination Service Committee (Wales) Directions 2016 (with consolidated amendments)	05/01/2024	Amendments to the eye health examination directions, collating information on qualified practitioners providing enhances optometry services. This is for oversight and governance purposes.	COO	Implemented with delegated functions provided by Shared Services Partnership on behalf of the Health Board. Some aspects ongoing including WGOS 3 mobile providers and students.	Complete	The Eye Health Examination Service Committee (Wales) Directions 2016 (with consolidated amendments) GOV.WALES	08/01/2024	18/03/2024	
Wales Eye Care Services (Administrative List) (Wales) Directions 2024	05/01/2024	The directions require local health boards to prepare and publish an administrative list of qualified practitioners (which includes dispensing opticians).	COO	Implemented with delegated functions provided by Shared Services Partnership on behalf of the Health Board.	Complete	Wales Eye Care Services (Administrative List) (Wales) Directions 2024 GOV.WALES	08/01/2024	18/03/2024	
The Low Vision Service Committee (Wales) Directions 2016 (with consolidated amendments)	05/01/2024	Amendments to the low-vision services directions, collating information on qualified practitioners providing enhanced optometry services. This is for oversight and governance purposes.	COO	Implemented with delegated functions provided by Shared Services Partnership on behalf of the Health Board.	Complete	The Low Vision Service Committee (Wales) Directions 2016 (with consolidated amendments) GOV.WALES	08/01/2024		

The National Health Service (Wales Eye Care Services) (Wales)(No. 2) Directions 2024	05/01/2024	Amendments to existing directions, including extra requirements on local health boards when arranging Enhanced Optometry Services and the Low Vision Service.	COO	Implemented with delegated functions provided by Shared Services Partnership on behalf of the Health Board.	Complete	The National Health Service (Wales Eye Care Services) (Wales) (No. 2) Directions 2024 GOV.WALES	08/01/2024		
Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2024	14/02/2024	Directions to local health boards on amendments to the general medical services contract	Director of Finance	Actioned automatically by SSP	Complete	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2024 GOV.WALES	21/02/2024		
Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2024	14/02/2024	Directions to local health boards on amendments to the general medical services contract	Director of Finance	Actioned automatically by SSP - confirmation has been sought from all independent GMS contractors that 5% uplift has been applied	Complete	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2024 GOV.WALES	21/02/2024		
The National Health Service Joint Commissioning Committee (Wales) Directions 2024	29/02/2024	The directions allow for the functions and membership of the NHS Wales Joint Commissioning Committee	Director of Corporate Governance		Complete	The National Health Service Joint Commissioning Committee (Wales) Directions 2024 GOV.WALES			
The Directions to Local Health Boards and NHS Trusts in Wales 2003 and the Managed Introduction of New medicines into the National Health Service in Wales Directions 2009 (Amendment)(Wales) Directions 2024	29/04/2024	The amendment Directions provide details of exemptions for the New Treatment Fund	Medical Director	The New Treatment Fund ensures dedicated resource is available to support Health Boards in making medicines and interventions recommended by NICE and AWMSG available within no more than two months of the publication of a NICE technology appraisal or highly specialised technology assessment, and an AWMSG recommendation being endorsed by Welsh Ministers.	Complete	The Directions to Local Health Boards and NHS Trusts in Wales 2003 and the Managed Introduction of New Medicines into the National Health Service in Wales Directions 2009 (Amendment) (Wales) Directions 2024 GOV.WALES	30/04/2024		
Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment)(No 2) Directions 2024	19/04/2024	Directions to the Local Health Boards as to the Statement of Financial Entitlements (Amendment)(No2) Directions 2024	Director of Finance		Complete	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2024 GOV.WALES	30/04/2024	08/08/2024	

WHC No	Date Issued	Review Date	Name of WHC	Summary	Status	Lead Executive (issued to)	Progress	Rating	Link
WHC/2022/007	15/02/2022	31/03/2023	Recording of Dementia Read Codes	Sets out the Read codes which should be captured by memory assessment and GP/primary care services and recorded on all information shared between services, to the person living with dementia and their carer (if they wish to receive this information), and within the Memory Assessment Service, Learning Disability Memory Assessment Service and primary care data bases. It also sets out guidance for Welsh Health Boards to assist with the recoding of a diagnosis of dementia using the	Action	Director Primary Care, Community and Mental Health Services	Issued and Implemented	complete	recording-of-dementia-read-codes-whc-2022-007.pdf (gov.wales)
WHC/2022/014	01/03/2022	31/03/2023	Healthcare associated infections and antimicrobial resistance improvement goals	Extension of WHC to 31 March 2023	Action / Information	Director of Nursing	The HCAI Welsh Government expectations against the nationally reportable infections are reported at every PQSO Committee, with performance oversight via RNTG.	complete	amr-hcai-improvement-goals-for-2021-2023.pdf (gov.wales)
WHC/2022/011	24/03/2022	01/06/2022.. Update issued September 2022	COVID-19 patient testing framework	Updated guidance based on the need to introduce proportionate and effective changes which balance the risks from SARS-CoV-2 against the need to deliver routine and emergency healthcare safely, and the impact that testing regimes have on patients	Action	Director of Public Health	Issued and Implemented	complete	https://gov.wales/sites/default/files/publications/2022-05/patient-testing-framework-updated-guidance%20%282%29.pdf
WHC/2022/010	29/03/2022	N/A	Reimbursable vaccines and eligible cohorts for the 2022 to 2023 NHS seasonal influenza (flu) vaccination programme	General practices, community pharmacies and health boards/trusts should plan to order their influenza vaccine to match the high levels of uptake achieved in 2021-22	Action	Director of Public Health	Issued and Implemented	complete	https://gov.wales/sites/default/files/publications/2022-03/reimbursable-vaccines-and-eligible-cohorts-for-the-202223-nhs-seasonal-influenza-flu-vaccination-programme.pdf
WHC/2022/005	24/03/2022	31/03/2025	Welsh Value in Health Centre: data requirements	Health Boards and Trusts are required to supply the clinical audit/registry data to DHCW to support the work of the Welsh Value in Health Centre and in particular to: Continue to submit data to UK-wide clinical audit and outcome reviews and national PROMs platforms; Provide audit and PROMs data to DHCW for the purposes of creating visualisations and dashboards for Value Based Health Care	Action	Director of Digital	Issued and Implemented	complete	welsh-value-in-health-centre-data-requirements.pdf (gov.wales)
WHC/2022/09	04/04/2022	28/02/2023	Prioritisation of COVID-19 patient episodes by NHS Wales clinical coding departments	Following review, the decision has been made that there is no longer a requirement to prioritise the assignment of classifications codes to inpatient episodes of care involving COVID-19 ahead of other types of inpatient activity. This decision supports the transition from COVID-19 as a pandemic to being an endemic condition. Therefore WHC/2022/009 has been withdrawn .	Withdrawn	Director of Planning and Performance	continue to prioritise the coding of COVID-19 patients as per the WG directive.	complete	https://gov.wales/sites/default/files/publications/2022-04/prioritisation-of-covid-19-patient-episodes-by-nhs-wales-clinical-coding-departments_0.pdf
WHC/2022/006	21/04/2022	30/04/2026	Direct paramedic referral to same day emergency care: All Wales policy	Publication of an all-Wales policy to support the Welsh Ambulance Services NHS Trust (WAST) and health boards in implementing direct paramedic referrals into Same Day Emergency Care (SDEC).	Action	Director of Operations	Current Position: Paramedics can via the flow centre refer Medical and Surgical patients to SDEC GUH and Medical to SDEC YFF. WAST referrals are triaged on arrival at the GUH and will be considered for SDEC under the ED-to-SDEC Pathway. We have introduced an SDEC advice line week commencing 6th November accessible to paramedics and primary Care	complete	https://gov.wales/sites/default/files/publications/2022-04/direct-paramedic-referral-to-same-day-emergency-care-all-wales-policy.pdf
WHC/2022/13	27/04/2022	01/04/2023	Health boards, special health authorities and trusts financial monitoring guidance 2022 to 2023	2022/23 LHB, SHA and Trust monthly financial monitoring return guidance and associated submission templates.	Compliance	Director of Finance	Issued and Implemented	complete	202223-lhb-sha--trust-monthly-financial-monitoring-return-guidance.pdf (gov.wales)

WHC/2022/015	01/06/2022	N/A	Changes to the vaccine for the HPV immunisation programme	Information on the forthcoming changes to the human papillomavirus (HPV) immunisation programme. Aimed at health professionals who are responsible for delivering the programme. Share guidance with all those who are involved in delivering the national HPV vaccination programme in your area.	Action	Director of Public Health	Information on changes to schedules is cascaded centrally from PHW and WG	complete	changes-to-the-vaccine-for-the-hpv-immunisation-programme_0.pdf (gov.wales)
WHC/2022/16	01/06/2022	N/A	The national influenza immunisation programme 2022 to 2023	Increase in influenza vaccination coverage in all groups that are eligible for the vaccine, to best protect the Welsh public.	Action	Director of Public Health	Dual offer made alongside covid in mass vaccination centres.	complete	https://gov.wales/sites/default/files/publications/2022-06/the-national-influenza-immunisation-programme-2022-23_1.pdf
WHC/2022/002	14/06/2022	01/04/2023	NHS Wales national clinical audit and outcome review plan annual rolling programme for 2022 to 2023	Full participation in all national clinical audits and outcome reviews listed in the annual National Clinical Audit & Outcome Review Annual Plan.	Information/ Action	Medical Director	The new clinical audit plan (soon to be published) has a full list all national clinical audits and outcome reviews listed in the annual National Clinical Audit & Outcome Review Annual Plan.	Complete	https://gov.wales/sites/default/files/publications/2022-06/nhs-wales-national-clinical-audit-and-outcome-review-plan-annual-rolling-programme-for-202223.pdf
WHC/2022/12	16/06/2022	31/12/2026	Donation and transplantation plan 2022 to 2026	Health boards and NHS trusts, where appropriate, are expected to work with the Welsh Health Specialised Services Committee (WHSSC), Welsh Renal Clinical Network (WRCN), NHS Blood and Transplant (NHSBT), Welsh Transplantation Advisory Group (WTAG), third sector and other relevant organisations towards implementing the priorities and actions in the Donation and Transplantation Plan for Wales. Health boards should take account of the priorities for donation and transplantation when planning their services and developing their	Action	Director of Planning and Performance	Plan is accounted for as part of IMTP planning processes.	complete	https://gov.wales/sites/default/files/publications/2022-06/donation-and-transplantation-plan-for-wales-2022-2026.pdf
WHC/2022/17	16/06/2022	31/12/2026	Wales rare diseases action plan 2022 to 2026	Highlight the publication of the Wales Rare Disease Action Plan (2022-2026).	Action / Information	Medical Director	The publication of the RDAP has been highlighted and shared with clinical leads across several specialities. Work is ongoing to	complete	https://gov.wales/sites/default/files/publications/2022-06/wales-rare-diseases-action-plan-2022%E2%80%932026-whc-2022-017_3.pdf
WHC/2022/019	21/06/2022	01/04/2025	NHS Wales non specialised paediatric orthopaedic services	To ensure that this service specification is used to inform the delivery and commissioning of Non Specialised Paediatric Orthopaedic Services for children (aged up to 16 years) resident in Wales	Action	Director of Operations	Stakeholder response Proforma submitted in March 2022 outlining service provision of level 1 and level 2 services. Both services are able to be maintained in ABUHB with the current level of paediatric anaesthetic, radiology and general medical cover. Inter-organisational discussions between Consultants ongoing to agree on levels of transfer according to available capacity.	complete	https://gov.wales/sites/default/files/publications/2022-07/non-specialised-paediatric-orthopaedic-services.pdf
WHC/2022/18	30/06/2022	N/A	Suspected cancer pathway: guidelines	Guidelines for Managing Patients on the Suspected Cancer Pathway	Compliance	Director of Operations	Fully compliant	complete	https://gov.wales/sites/default/files/publications/2022-07/guidelines-for-managing-patients-on-the-suspected-cancer-pathway_2.pdf
WHC/2022/20	22/07/2022	Continuous review	Never events: policy and incident list July 2022	Updated list of Never Events (remove wrong tooth extraction)	Compliance / Action / Information	Director of Nursing	SI team shared the WHC with the divisions and also published on the intranet	complete	https://gov.wales/sites/default/files/publications/2022-07/whc-2022-020-never-events-policy-july-2022.pdf
WHC/2022/21	28/07/2022	30/09/2022	National optimal pathways for cancer	The Quality Statement for Cancer requires that the nationally optimised pathways are fully embedded in local service delivery.	Action	Medical Director	Issued and Implemented	complete	https://gov.wales/sites/default/files/publications/2022-08/national-optimal-pathways-for-cancer-2022-update.pdf
WHC/2022/008	29/07/2022	01/05/2023	New records management code of practice for health and care 2022	Notification of the publication of the new Records Management Code of Practice for Health and Care 2022 and to advise Chief Executives, Directors of Social Care, Health and Care Records Managers and all line managers and supervisors within the relevant organisations that they should use it from May 2022.	Compliance / Action	Director of Digital	Issued and Implemented	complete	https://gov.wales/sites/default/files/publications/2022-07/new-records-management-code-of-practice-for-health-and-care-2022.pdf
WHC/2022/022	22/08/2022	01/08/2024	The role of the Community Dental Service	Updated guidance on the role of the community dental service, including the expansion of salaried dental officer posts, to support local communities who have limited or no access to general dental services normally provided by the independent contractor model. Ensure that arrangements are in place to implement this guidance.	Action	Director of Primary, Community and Mental Health Services	Discussed at Primary Care Senior Leadership Team and satisfied that progress is being made in line with the WHC	In progress	https://gov.wales/sites/default/files/publications/2022-08/the-role-of-the-community-dental-service.pdf

WHC/2022/023	09/09/2022	N/A	Changes to the vaccine for the HPV immunisation programme	Information on the recently announced changes to the human papillomavirus (HPV) immunisation programme. Aimed at health professionals who are responsible for delivering the programme. Share the information with all those who are involved in delivering the national HPV vaccination programme in your area.	Information		Information on changes to schedules is cascaded centrally from PHW and WG	complete	changes-to-the-vaccine-for-the-hpv-immunisation-programme-whc2022023.pdf (gov.wales)
WHC/2022/026	11/10/2022	01/10/2023	Approach for Respiratory Viruses – Technical Guidance for Healthcare Planning	Letter to health professionals about the approach for responding to respiratory viruses over autumn and winter.	Action	Director of Public Health	Forwarded to relevant parts of the organisation.	complete	approach-for-respiratory-viruses-technical-guidance-for-healthcare-planning.pdf (gov.wales)
WHC/2022/027	24/10/2022	N/A	Urgent polio catch-up programme for children under 5 years old	Health Board's to carry out a 'targeted' immunisation catch-up programme across Wales. Targeting children under 5 with partial or no vaccination against Polio without delay. This is a priority project which will need to commence as soon as possible and be completed by 31 January 2023 at the latest, after which time the NES will no longer apply...."	Action	Director of Public Health / Interim Director Primary, Community and MH Services	Implemented - gone beyond requirements: MVCs offered scheduled imms. to children in 17 GP practices that opted out of enhanced service inc. domiciliary vaccination visits.	complete	urgent-polio-catch-up-programme-for-children-under-5-years-old.pdf (gov.wales)
WHC/2022/003	31/10/2022	01/10/2025	Guidance for the provision of continence containment products for Adults in Wales 2022	Consensus document regarding the provision of continence containment products for adults, to ensure all adults who suffer with urinary or faecal incontinence, undergo a comprehensive assessment and have access to an equitable service	Compliance/ Action/Information	Director of Nursing	Issued and Implemented	complete	https://www.gov.wales/adult-continence-products-whc2022003
WHC/2022/004	31/10/2022	01/08/2025	Guidance for the care of children and young people with continence problems	Consensus guidance document regarding the provision of continence containment products to children and young people, to ensure all children and young people who have not toilet trained, or have urinary or faecal incontinence, undergo a comprehensive assessment and have access to an equitable service	Action	Director of Nursing	Issued and Implemented	complete	https://www.gov.wales/paediatric-continence-containment-products-whc2022004
WHC/2022/029	22/11/2022	N/A	Follow-up advice on the polio catch-up programme for children under 5 years old	extension to deadline in WHC/2022/027 to 31st March 2023	Action	Director of Public Health / Interim Director Primary, Community and MH Services	As above: since April we have sought self-reported uptake from GPs delivering enhanced service. MVCs currently evaluating uptake within 17 opt out practices.	complete	https://www.gov.wales/follow-advice-polio-catch-programme-children-under-5-years-old-whc2022029
WHC/2022/031	08/12/2022	N/A	Reimbursable vaccines and eligible cohorts for the 2023 to 2024 NHS seasonal influenza (flu) vaccination programme	Letter to health professionals about the 2023 to 2024 NHS seasonal influenza vaccination programme.	Action	Director of Public Health	Issued and Implemented: position endorsed by Gwent LMC.	complete	https://www.gov.wales/reimbursable-vaccines-and-eligible-cohorts-2023-2024-nhs-seasonal-influenza-flu-vaccination
WHC/2022/025	16/12/2022	02/12/2025	All Wales guidance for prescribing intervals	Health boards should notify general practitioners of the change and work with them to encourage the use of longer prescribing intervals where appropriate. Doing so will have benefits for general practice, community pharmacy, and patients and their carers.	Action	Medical Director	message sent to all practices on 6/5/22 . This theme is also included in the work programme for the medicines management team for this coming year.	complete	https://www.gov.wales/sites/default/files/publications/2023-03/all-wales-guidance-for-prescribing-intervals.pdf
WHC/2022/035	22/12/2022	N/A	Influenza (flu) vaccination programme deployment 'mop up' 2022 to 2023	Letter to health professionals on mop-up activity for the seasonal influenza vaccination programme 2022 to 2023	Action	Director of Public Health	Issued and Implemented: MVCs offered walk-in service from end of Dec '22 and by the end of the season administered over 7,000 additional vaccines	complete	https://www.gov.wales/influenza-flu-vaccination-programme-deployment-mop-2022-2023-whc2022035
WHC/2022/034	15/02/2023	N/A	Health board allocations for 2023 to 2024	This letter notes health boards' funding arrangements for the coming financial year.	Action	Director of Finance	Complete and has informed the IMTP and budget setting / delegation approvals	complete	https://www.gov.wales/sites/default/files/publications/2023-03/health-board-revenue-allocations-2023-to-2024.pdf

WHC/2022/032	24/03/2023	01/04/2024	Further extending the use of Blueteq in secondary care	Following successful implementation of the system by WHSSC, the Minister for Health and Social Care has agreed that Blueteq use should now be extended to a wider range of medicines to support improved financial governance and collecting information about the use of medicines in priority areas for the NHS.	Action	Medical Director	The following is taken from discussion at the Chief Pharmacists meeting of 3/4/23 with representatives of AWTTTC. Plan to discuss at MMPB 13/4/23. "Following the WG mandate to implement Blueteq within all HBs/Trusts a number of questions have been raised. Implementation will be through a staged approach and the aim is to start off with Rheumatology and then Haematology. BCUHB is to undertake a pilot in rheumatology and HBs will be able to learn from this and share how they have approached it e.g. training etc. Templates have been produced and the plan is to have a generic template that can be used across Wales so individual HBs/Trust don't need to develop their own. BCUHB is in the process of working through the IG and DPIA issues and hope to start the pilot in May. For Haematology it is planned to look at all drugs that have commercial access agreements linked to them and develop	complete	Further extending the use of Blueteq in secondary care (gov.wales)



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	12 September 2024
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Committee Risk and Assurance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Corporate Risk and Assurance

Pwrpas yr Adroddiad (dewiswch fel yn addas) Purpose of the Report (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT
<u>Sefyllfa / Situation</u> This report presents the Audit, Risk and Assurance Committee (the Committee) with an assessment of the strategic risks related to the Board's strategic priorities and provides assurance that these risks are being effectively managed. It also aims to provide reassurance regarding the advancements being made in enhancing risk management within the Health Board.
<u>Cefndir / Background</u> The Strategic Risk Report, which was last presented to the Committee on 09 July 2024, comprised eight principal risks and 20 sub-risks. Following a review by the Board on 17 July 2024, it was agreed to de-escalate SRR 001H, below, to the Corporate Risk Register, recognising that the risk is primarily focused on financial stability and the optimisation of resources, which are better addressed and managed by the Executive Team. 'There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population, due to the Public Health Directorate being heavily reliant on non-recurrent funding grants.'

As of the end of July 2024, the Strategic Risk Register consisted of **eight** principal risks and **19** sub-risks.

The Board has delegated responsibility to various committees to oversee and scrutinise assurances related to specific strategic risks that are directly linked to the Committee's agenda. This delegation of responsibility ensures that each strategic risk is managed with the appropriate level of oversight and expertise, aligning with the Board's overall risk management framework.

Asesiad / Assessment

Strategic Risk Register

In accordance with best practices, all strategic risks have undergone a thorough review to ensure that the control environment is robust and adequate for managing the identified risks. Where it has been determined that the existing controls are insufficient, the necessary additional controls have been documented, and actions are currently being taken to address these gaps. Similarly, assurances are evaluated across all three lines of defence to ascertain the effectiveness and reliability of the controls in place. If gaps in assurance are identified, the control environment is reassessed, and appropriate measures are implemented to close these gaps.

A high-level summary of the **eight** principle strategic risks are presented in Table 1 with further detail included in **Appendix A** (Strategic Risk Dashboard and individual risk assessments for the 19 sub-risks).

To note, **SRR 001E**, **SRR 007A** and **SRR 008A** have a risk score of 8 (moderate risk), therefore are not accounted for in the risk level columns in Table 1. Only the number of 'High' and 'Extreme' risks are provided.

Table 1

Overarching Strategic Risk Description	Sub-Risks	Risk Level		Sub-Risk Theme	Delegated Committee
		High (9 – 12)	Extreme (15 – 25)		
SRR 001 - There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population.	A, B, C & D	3	1	People	People and Culture Committee
	*E & F	-	1	Service Delivery	Partnerships, Public Health & Planning Committee
	G	-	1	Financial Sustainability	Finance and Performance Committee
	I	-	1	Compliance and Safety	Finance and Performance Committee
SRR 002 - There is a risk that there will be significant failure of the Health Board's estate.	A & B	1	1	Compliance and Safety	Partnerships, Public Health & Planning Committee

SRR 004 - There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to a major incident, business continuity incident or critical incident.	A	1	-	Compliance and Safety	Partnerships, Public Health & Planning Committee
SRR 005 - There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.	A	1	-	Service Delivery	Patient Quality, Safety & Outcomes Committee
SRR 006 - There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.	A, B & C	2	1	Service Delivery	Finance and Performance Committee
SRR 007 - There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	*A & B	1	-	Transformation & Partnership Working	Partnerships, Public Health & Planning Committee
SRR 008 - There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.	*A	-	-	Transformation & Partnership Working	Patient Quality, Safety & Outcomes Committee
SRR 010 - The Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974	A	-	1	Compliance and Safety	Patient Quality, Safety & Outcomes Committee
TOTAL	19	9	7		

Since the last presentation of this report to the Committee and the subsequent review of all strategic risks, the overall strategic risk environment has remained reasonably stable. However, the Committee should be aware of six sub-risks that remain outside the acceptable risk threshold for their respective domains. These are subject to ongoing discussions with executive leads and responsible officers to determine what additional mitigation measures are required to reduce the likelihood or impact of these potential threats.

The status of these **six** sub-risks and the sources of assurance are detailed below, providing the Committee with the reassurance that addressing risks outside the Health Board's appetite remains a priority.

SRR 001G: Currently rated as "Extreme" with a score of 20 (Likelihood 5 x Impact 4), concerns the potential inability of the Health Board to sustain high-quality, safe, and sustainable services due to challenges in achieving a sustainable financial position and a long-term financial plan.

Despite the implementation of comprehensive mitigation measures, further controls are necessary to bring the risk within acceptable levels. The Executive Committee is placing a strong emphasis on adherence to these controls, which are fundamental to the successful delivery of the Board-approved Three-Year Route Map to Service and Financial Sustainability.

The recent internal audits on the 2023/24 Savings Programmes and Financial Controls have provided reasonable and substantial assurance, respectively. Looking ahead, the upcoming 2024/25 Financial Sustainability Internal Audit, scheduled for the third quarter, will offer additional evidence on the effectiveness of the current risk management strategies.

SRR 001I: Currently rated as "Extreme" with a score of 16 (Likelihood 4 x Impact 4), pertains to the potential failure of the Health Board to implement the necessary performance improvements in key areas of the organisation, as specified in the Health Board's Performance Management Framework. This includes critical domains such as Quality and Safety, Operational Delivery, and Finance. This risk is relatively new, having been approved by the Board in March 2024.

An improvement plan has been developed, with specific actions targeting areas that are under a level of escalation. The aim of this plan is to strengthen areas where weaknesses have been identified and to drive operational and cultural improvements, thereby enhancing overall performance.

Assurance that this risk is being managed effectively will be supported by the outcomes and findings of several internal audits scheduled for the coming quarters. These audits include reviews of Divisional Governance Arrangements and the Directorate Review of Mental Health and Learning Disabilities in Quarter 2 of 2024/25, as well as the Performance Framework audit planned for Quarter 3 of 2024/25.

SRR 002A: Currently rated as "Extreme" with a score of 15 (Likelihood 3 x Impact 5), addresses the structural integrity and safety of buildings within the Health Board's estate, specifically concerning the presence of Reinforced Autoclaved Aerated Concrete (RAAC). RAAC is a material known for its susceptibility to degradation over time, leading to potential structural weaknesses.

The ongoing development of the Nevill Hall site is a critical component of the Health Board's response to this risk, addressing both the changing population needs and the remediation required to address RAAC-related risks.

Assurance that the risk related to RAAC is being managed effectively will be evidenced by the outcome of a focused internal audit review of RAAC, scheduled for Quarter 1 of 2024/25.

SRR 002B: Currently rated as "high" with a score of 12 (Likelihood 3 x Impact 4), focuses on the significant levels of backlog maintenance and existing structural impairments within the Health Board's estate. These factors collectively create a serious risk of building failure, which could have severe consequences for the health and safety of patients, staff, and the ongoing operations of the Health Board.

The Board was informed at its July meeting that the Health Board would be receiving £4 million in funding from the Welsh Government to address the backlog of maintenance, and that the works would be undertaken on a priority basis.

The Internal Audit into Estates Assurance, more specifically energy management, scheduled for Quarter 4 of 2024/25 may provide a level of assurance that the backlog maintenance plan is helping to deliver efficiencies in terms of utility expenditure.

SRR 004: Currently rated as "Extreme" with a score of 15 (Likelihood 3 x Impact 5), pertains to the Health Board's potential inability to effectively manage and respond to major incidents, business continuity disruptions, or critical situations.

This vulnerability stems from inadequate and insufficient emergency planning at both the corporate (strategic) and operational (tactical) levels. The potential consequences of this risk are significant, as a lack of preparedness could lead to delayed, inefficient, or ineffective responses during crises, thereby compromising patient care, public safety, and the overall continuity of essential services.

Internal Audit plans to review the Health Board's technical resilience and awareness of fault domains to ensure that the Health Board is maximising its potential for resilience within its infrastructure. This review, scheduled for Quarter 3 of 2024/25, will provide assurance of the Health Board's preparedness to react and manage a digital critical incident. Additionally, assurance of preparedness for major incidents can be evidenced through the outcome reports from local and national exercises.

SRR 010 currently rated as "High" with a score of 12 (Likelihood 3 x Impact 4), addresses the Health Board's potential failure to adequately protect the health and safety of its staff, patients, and visitors. This is a fundamental duty under the Health and Safety at Work Act 1974.

The risk arises from the possibility that the Health Board's systems, processes, governance structures, and assurance mechanisms may be inadequate or ineffective in implementing, embedding, and monitoring compliance with the Act's requirements.

Assurance that this risk is being managed effectively will be provided by the outcome of the Health and Safety Internal Audit, scheduled for Quarter 4 of 2024/25. The Committee will also be able to take a level of assurance from the 2023/24 Health and Safety Annual Report, which will be received by the Board in the coming months.

Risk Exposure

In terms of the Health Board's current risk exposure to the **19** strategic sub-risks, the infographic below illustrates that most strategic risks are in the upper right quadrant of the risk matrix, indicating a high level of risk exposure. As previously stated in the report, six of these risks fall outside the Board's agreed-upon appetite level.

Risk Scoring Matrix					
Likelihood/ Frequency	Consequence/Impact				
	1. Negligible	2. Minor	3. Moderate	4. Major	5. Catastrophic
5. Almost Certain (91%)				1 x (Extreme)	
4. Likely (61-90%)				2 x (Extreme)	
3. Possible (41-60%)			1 x (High)	10 x (High)	2 x (Extreme)
2. Unlikely (11-40%)				3 x (Moderate)	
1. Rare (1-10%)					

The Corporate Governance Directorate continues to work with risk owners to evaluate and improve controls and assurances, as well as to increase transparency about the work being undertaken to implement mitigation in the short, medium, and long term. This will be demonstrated by a revised risk assessment template that places a greater emphasis on the high-level actions being taken to implement additional controls to bring the risk within appetite or to a level at which the Board is willing to tolerate the risk. This will be reviewed by the Executive Team and this Committee before submitting to a future Board meeting for formal approval.

The closing position as at the end of August 2024, is that the Strategic Risk Register includes **eight** high-level strategic risks and **19** sub-risks, **six** of which are managed outside of their predefined risk appetite level.

Corporate Risk Register

Due to recent operational challenges, the Executive Team was unable to review the draft corporate risk portfolio during its scheduled session in July 2024. These challenges included unanticipated resource constraints and shifting priorities that required immediate attention, delaying the risk review process. However, the Corporate Risk Register will be considered in an upcoming Executive Team weekly business meeting. This will ensure that all proposed corporate risks are thoroughly evaluated, and necessary adjustments are made to the risk portfolio before being reported through this Committee and to the Board.

A comprehensive report, incorporating the latest risk assessments and any newly identified risks, will be presented to the Board in November 2024. This report will provide an updated status of all strategic and corporate risks, ensuring that the Board has a clear understanding of the current risk landscape. Following this, all risks will be included in subsequent reports to the Committee, ensuring continued oversight and alignment with the Board's risk management framework.

Risk Management Processes and Systems

As the Committee will recall from previous reports, a national piece of work was commissioned in 2020 to develop a "Once for Wales Risk Management System". This

initiative aimed to create a standardised workflow and associated data fields for the Enterprise Risk Management function within Datix Cymru, intended for use by NHS Wales Health Bodies.

The Risk Workstream, which was commissioned to oversee this initiative, has now reached a pivotal stage in its development. The Once for Wales Central team has indicated that the module meets the specifications established by the programme and would like organisations to agree to migrate to the new the Datix Cymru from November 2024, with the possibility for further refinement following implementation by NHS Wales organisations. The Risk Group has expressed significant concerns regarding the system in its current state. These concerns include the lack of essential core functionalities, reliable reporting capabilities, and overall readiness of the system. As it stands, the system does not meet the standards expected of an intuitive and dependable risk management tool. Significant work remains to bring the system to a level where it can be confidently implemented and relied upon to manage risks effectively.

The current contractual position indicates that, as of 30 November 2024, there will be additional costs for organisations wishing to continue using the legacy DatixWeb system. Further information has been requested regarding the costs and how they would be implemented should health bodies choose to retain DatixWeb until 2027, or until a new system is procured. This information will be presented in a report to the Director of Corporate Governance's meeting on 06 September 2024. An update on the outcome of this discussion will be shared at the meeting.

It has been communicated that DatixWeb will remain available until 2027 at an annual cost.

In the meantime, work continues to cleanse and optimise the current DatixWeb system, should the Health Board choose to continue using this system until a new risk management system is procured. This ongoing effort is critical to ensuring that the Health Board maintains a functional and reliable risk management system in the interim period.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is requested to:

- **NOTE** the Strategic Risk Register and the Risk Assessments for the 19 sub-risks, acknowledging the comprehensive review and ongoing management of these risks;
- **CONSIDER** whether it has sufficient assurance that the strategic risks are being assessed, managed, and reviewed appropriately and effectively, considering the detailed analysis and ongoing mitigation efforts outlined in this report;
- **NOTE** the risks that remain outside of the agreed-upon appetite for their respective risk domains, recognizing the ongoing efforts to mitigate these risks and bring them within acceptable levels;
- **NOTE** the current position and challenges associated with the "Once for Wales Risk Management Module," including the concerns raised by the Risk Group and the potential implications for the Health Board's risk management processes; and,

- **NOTE** the continued work to mature and enhance risk management within the Health Board, with a particular focus on improving transparency, control environments, and assurance mechanisms.

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

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termiau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	At each meeting, the relevant Committee will monitor the risk theme relevant to its responsibilities.

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

	development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• Workforce	Not Applicable
• Service Activity & Performance	Not Applicable
• Financial	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Choose an item.

Strategic Risk Dashboard

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

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

Key	Current Score	●
	Target Score	✖
	Appetite Threshold	○
	Current to target	←

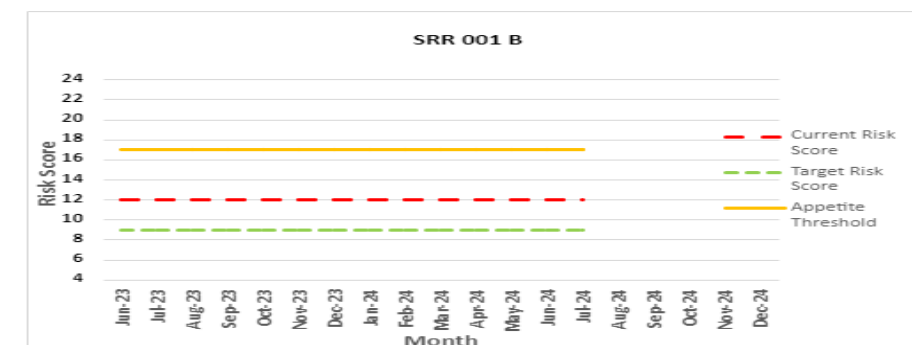
RISK THEME	PEOPLE				
Strategic Risk - SRR 001	The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.			Publication Status	Public
Strategic Threat	a) Due to an inability to recruit and retain staff across all disciplines and specialties.			Risk Appetite Level – Open Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	- Adverse impacts on delivery of care to patients across acute and non-acute settings - Non-compliance with safe staffing principles and standards - Reliance on agency and bank staff - Litigation & Financial Penalties			Risk Appetite Threshold - Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.	
				SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
Lead Director	Director of Workforce & Organisational Development	Risk Exposure	Current Level	Target Level	SRR 001A Current Risk Score Target Risk Score Appetite Threshold
Monitoring Committee	People & Culture Committee	Likelihood	4 <i>(Likely)</i> x	3 <i>(Possible)</i> x	
Initial Date of Assessment	01 June 2023	Impact	4 <i>(Major)</i>	2 <i>(Minor)</i>	
Last Reviewed	01 August 024	Risk rating	= 16 <i>(Extreme)</i>	= 6 <i>(Moderate)</i>	
Next Review Monthly based On current score	01 September 2024				

Key Controls (What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control (Are further controls possible to reduce risk exposure within tolerable range?)	Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective)	Gaps in Assurance/ Actions to Address Gaps (Insufficient evidence as to the effectiveness of the controls or negative assurance)	Assurance Rating (Overall Assessment)
- Monitoring Framework to support roll-out of the People Plan. - Workforce Dashboard to track activity – recruitment, turnover, sickness absence. - Supply and demand tracker (Nursing and HCSW). - People Plan tracker to support delivery of actions within the People Plan 2022-25. - Variable Pay Reduction Plan approved June 2022 and supported by the Programme Board. - Management of attendance through All Wales Management Attendance at Work Policy. - Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture. - Nurse Staffing Levels (Wales) Act 201625b/25c. - Review of staffing and recruitment plan internally in line with Royal College Guidance, i.e., RCP. - Workforce planning supported by Compendium of new roles to support innovative workforce models. - Recruitment KPI's. - IMTP (Integrated Medium-Term Plan) Educational Commissioning. - Workforce Establishment controls national working group has been instigated. - Value and Sustainability Board. - Collective Agreement (Non-Pay Deal) 2022/24	Retention - Development of career pathways (e.g., non-clinical to clinical). - Talent management and succession planning framework and resources now live and available on SharePoint. Framework signed off by Executive Committee. - Career conversations and succession planning resources designed; workshop dates available with spaces for 120 people (with monthly training sessions available). - All Wales self-assessment retention tool completed and submitted to HEIW with assessment at organisational level for Nursing and Midwifery to provide a baseline. - NHS Wales Nurse Retention Plan quarterly updates being reviewed for submission 09 Sept 2024 - Short project in progress with an MSc student to develop a retention dashboard, using a regression model to better understand and predict retention E- Systems - Utilise benefits of roll out Safe Care staffing to support effective and efficient staff deployment within adult ward areas. - Roll out of medical rostering to predict junior doctor gaps and look for alternative ways to fill.	Level 1 Operational (Implemented by the department that performs daily operation activities) - Workforce reports to the Nurse Strategic Workforce Group. - Monthly sickness monitoring reports. - Weekly filled and unfilled shift reports (RN) and reports of agency for HCSW/RN. - Medical Staffing Co-ordinator review of medical rotas. - Cross site operational calls. - Occupational Health and Wellbeing dashboards report KPIs. - Recruitment KPIs - Medical & Dental and Student Streamlining fill rate reports	Gaps in Assurance	Positive Assurance
		Level 2 Organisational (Executed by risk management and compliance functions.) - Reports to the People and Culture Committee and the Board on the progress of the People Plan 2022-25 - Workforce Dashboard presented to the Executive Committee, P&CC Committee, and the Board. - Workforce and OD (Organisational Development) group established to support delivery and implementation of workforce plans to support Clinical Futures Service transformation. - Measurements of Wellbeing through the ABUHB	Action to Address Gaps in Assurance	

- Engagement with national recruitment campaigns such as BAPIO, M&D Kerela Initiatives, Train, Work, Live and Student Streamlining for Registered Nurses, Physician’s Associates, Midwives, and therapy staff and with HEIW (Health Education and Improvement Wales) for Junior Doctor. - Annual programme of Apprentice recruitment - Overseas Nursing (All Wales Recruitment programme) - Nursing Workforce Strategy agreed - Streamlining and improving recruitment timescales through recruitment modernisation programme (started Oct 2022) - Partnerships with employability schemes and FE/HE to widen access. - Actively working with Local Authorities to promote joint recruitment activities via Gwent Workforce Board. Retention: - Retention lead appointed with programme action plan in place for the next two years. - Engagement chat cafes providing information and support for key topics such as Agile Working, Learning and Development, Wellbeing Activity, Occupational Health, and Complex HR. - Week of events planned to support retention agenda in June 2024. This will include a mixed method of online webinars, videos and retention materials. - Internal Retention group has been established with a view to 1) interrogating data from multiple sources to fully understand the issues 2) Turn the data into intelligence so that we can understand and respond to organisational and local level impacts. - Changes in pension regulation and flexile retirement options from October 2023 and reduced break in service required following retire and return. - Development of HCSW skills matrix and career framework has commenced. Variable pay reduction - Plan in place to monitor and review all agency, bank pay incentives supply and demand reporting to Value and Sustainability Board. E- Systems - Effective deployment of current staff - Programme Plan implemented to introduce Workforce Medical E-Systems to support effective deployment of medical staff. E-Locum Bank, E-Job Planning, E-Agency systems are all ‘live’ and rolled out within the Health Board. E-Rostering is planned to go live shortly following ESR interface testing. Development of alternative and new roles - A Gwent Strategic Workforce Action plan has been developed through co-production with our partners across Gwent, and now forms the basis of the Gwent Workforce Board programme of work and agenda. The Action plan has been developed around the 7 key principles of A Healthier Wales: Our Workforce Strategy for Health and Social Care - The NCN (Neighbourhood Care Networks) Workforce Planning programme commenced in Autumn 2023, with all initial workforce planning workshops with all 11 NCN areas completed. The programme is now moving into the next stage of the programme with a comprehensive workforce planning assessment of Blaenau Gwent as an initial project. Programme plan led by WOD developed in conjunction with NCN leads and Divisional Senior Management. Training	- Ensure compliance increase in e-job planning to optimise current resources and identify any gaps in provision. - Review and analyse the electronic Bank & Agency data from Patchwork to identify areas with high usage, reasons for use and potentially convert to substantive roles. Development of alternative and new roles - Continued implementation of new roles such as Physician Associates, Enhanced and Advanced roles to support workforce skills gaps in line with IMTP. - Updating of compendium of new roles and benchmarking is available via workforce planning intranet site and HEIW portal. - Looking to increase Assistant band 4 in Community/Mental Health. - Continue to extend scope of Advanced Clinical Practitioners to undertake new procedures, reporting etc reducing medical capacity. - Increasing consultant therapy and nurse practitioners. - RCN introduction of Registered Nurse Associate role to help build the capacity of the nursing workforce – students to start from September 2025 with placements from September 2027. - Development of new roles and career pathways to support hard to fill roles in Health Visiting. Training - HEIW are increasing the capacity of training through creating more spaces for training the future Primary Care workforce, including Primary Care Academy - Workforce planning training prospectus of local and online training will be available from October 2024. - Development opportunity being scoped for Business support staff. - Suite of learning masterclasses launched with 5 topics now available to book, including influencing skills, setting up teams for success, giving feedback, having courageous conversations, having a meaningful PADR. 236 attendees in July 2024. - Recruitment training for managers to streamline campaigns as much as possible to reduce time to hire. - Development of training doctor fill rate dashboard to monitor and improve fill rate or to inform alternative recruitment strategies.	(Aneurin Bevan University Health Board) Staff Survey. - Routine Reporting against nurse staffing levels. - Variable Pay Programme Board reporting to Value and Sustainability Board Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies.)</i> - Internal Audit Reviews 2023 -24 - Long Term Sickness Absence Management (Q4) - Flexible Working (Q4) - External quarterly vacancy reporting to WG - External reporting on Nursing Staffing Levels - National Acuity Audits (Nursing) - National Workforce Implementation Plan: Addressing NHS Wales Workforce Challenges - The Strategic Workforce Implementation Board will report to the Minister for Health and Social Services with a collective view from a range of key partners including policy and professional leads in WG, and representatives of NHS employers, staff organisations and professional representative.		

• The HEIW Education & Training Plan continues the investment in education and training in Wales that has been increasing over past years. In the HEIW Education Training Plan 22/23 there were increases in - Adult Nursing (36%) and Mental Health Nursing (20%), Healthcare science, Allied Health Professionals Clinical Psychology (11%- 43%). This will increase the number of graduates coming out of training in 2024 and beyond which are required to support turnover and existing vacancies. • The draft 2025/26 education and training plan proposes further increases in Wales training numbers in all branches of Nursing, health care science, medical speciality training junior doctors, pharmacy and continued increase in HCSW investment and increased placements in adult nursing in General Practice. • HEIW have increased Health Care Support Workforce Development funding and there have been further changes for accelerated training pathways in some areas so support entry graduate level qualifications. Improved HCSW funding has enabled clinical induction to be delivered in house from April 2024 to accelerate time to effectiveness and improve employee experience. • RN/HCSW Connect Programme has been established in connection with HEIW and higher education providers to support candidates enter registered nursing training (6 supported this year) • Cadet Nursing programme in place (20 candidates last year) • K102 bridging model now being offered to support HCSW pathways into registered nursing. • Development of Leadership Development programmes for key roles such as the Clinical Director post (CDx) is in its second year. Similar program for Directorate Managers (DMx) a 10-month leadership development program to support the capability of this key group commenced 23 April 2024. Nursing and Midwifery Academy for senior level nurses and midwives, Leadership Development program (entry level) and Leading People (advanced Level) programmes fully booked. Core Leadership programme currently delivering to 200 staff. Vacancy Numbers and establishment control • Quarterly reporting of vacancy numbers for each staff to the WG. Last reporting period March 2024 there were circa 619 WTE vacancies. Reduction 109 WTE from March 2023. The next WG quarterly reporting update is due September 2024. • Development of ESR establishments commenced on a national basis w/c 03 September 2023. Local delivery action plan has been developed and approved by Executive Committee in April 2024. Project workstream established and work commenced. Staff attendance • Support for staff who are absent in line with Managing Attendance at Work Policy, including those on long term absence with a view to signposting to self-help support, and adapting/adjusting roles to enable a safe return to work. • “Hot spot” areas identified and plans in place to support.				

RISK THEME	PEOPLE			
Strategic Risk - SRR 001	The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.			Publication Status Public
Strategic Threat	b) Due to a deterioration in, and a failure to improve, the well-being of staff.			Risk Appetite Level – Open Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.
Impact	➤ High absence levels, with some sustained long periods ➤ Adverse impacts on delivery of care to patients across acute and non-acute settings ➤ Non-compliance with safe staffing principles and standards ➤ Reputational damage to the health board as an employer ➤ Work-related industrial injury claims ➤ Moral injury			Risk Appetite Threshold – Open Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.
				SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
Lead Director	Director of Workforce & Organisational Development	Risk Exposure	Current Level	Target Level
Monitoring Committee	People & Culture Committee	Likelihood	3 (Possible) x	3 (Possible) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	3 (Moderate)
Last Reviewed	01 July 2024	Risk rating	= 12 (High)	= 9 (High)
Next Review Due Quarterly based on current score	01 October 2024			



Key Controls <i>(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>(Are further controls possible to reduce risk exposure within tolerable range?)</i>	Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance/ Actions to Address Gaps <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Assurance Rating <i>(Overall)</i>
- Monitoring Framework to support roll out of the People Plan. - Monitoring of absence, reasons for absence and trends in referrals to Occupational Health and Employee Well-being Service through Workforce Performance Dashboard. - Dashboard reported to Executive Team, TUPF and LNC colleagues and People and Culture Committee with regular summary of Well-being and Occupational Health activity. - Regular meetings with divisions to ensure staff are well supported and staff wellbeing is a priority. - Strategic Equality plan - Rest and Facilities charter – monitoring and compliance. - Staff related policies. - National Staff Survey and Health Board Employee Experience Survey - External Employee Assistance Programme - Speaking up Safely action plan - Race/LGBT groups. - Wellbeing resources - Occupational Health Service - Staff diversity networks - Regular Schwartz rounds arranged across the Health Board - Taking Care giving care Rounds integrated into our leadership offers and available for teams to undertake either with support or on their own. - Close links with the Arts in Health programme - Chaplaincy service for staff	- Increase wellbeing initiatives. - Identify, training and develop Respect and Resolution advocates (similar to Mental Health first aiders). - Work with Professional Nurse Advocates (PNA) to explore ways to offer high quality support to nursing colleagues. - Trained mediators so there is team and organisational resilience and network. - Scope, design and deliver a programme of research ‘Healthy Working Day’. - Enhanced our financial well-being offer. - Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate. - Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management. - The Avoidable Employee Harm Programme, launched on 05 July 2022 initially focusing on HR processes has resulted in a 70% reduction in investigations and a wide range of other organisational benefits. The programme has now won six awards including two from NHS Wales.	Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>	Gaps in Assurance	Positive Assurance
		- Dashboard reporting - Reporting to monitor the rollout of the People Plan 22-25 - Reporting to monitor of demand on wellbeing services	Understand if support is reaching all staff	
		Level 2 Organisational <i>(Executed by risk management and compliance functions.)</i>	Action to Address Gaps in Assurance	
		- People and Culture Committee reports (People Plan 22-25) - Local wellbeing surveys - LNC – reporting of compliance of BMA Rest and Facilities	Meetings with Divisions ongoing to ensure all areas are aware of what’s available.	
		Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies.)</i>		
		- National workforce surveys - Monitoring and compliance of BMA Rest and Facilities via NHS Employers - Staff Welfare Charter - Sickness Absence Audit 2023/24		

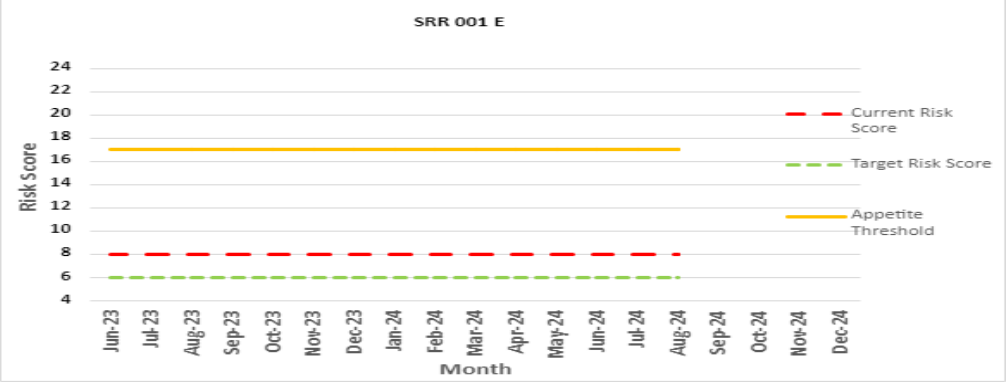
- Establishment of new bilingual Health and Well-being AB Pulse page on the intranet with library of resources for staff well-being - Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate. - Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management. - The Avoidable Employee Harm Programme, launched on 05 July 2022 initially focusing on HR processes has resulted in a 70% reduction in investigations and a wide range of other organisational benefits. The programme has now won six awards including two from NHS Wales and generated five peer reviewed journal papers. Year one reductions are remaining consistent in year 2. This programme has now expanded across Wales and is being supported by income generated with a collaboration with HEIW. - The Avoidable Employee Harm Programme model will be used to underpin our approach to the Speaking up Safely (SUS) initiative within ABUHB. This workstream began in October 2023 and will be developed over the next 12 months with a strong emphasis on evidence analysis and culture. The initial SUS Steering group was held on 14 March 2024, and an externally commissioned SUS hotline will be piloted in September 2024. - An external Employee Assistance Programme (Vivup) has been commissioned for 12 months to offer additional psychosocial wellbeing support to staff, including a waiting list initiative. Waiting times have now reduced on average by 30%. Occupational Health - Additional occupational health resources secured to reduce waiting times. - Occupational Health and NWSSP are working in partnership to implement a new Occupational Health Software system across Wales called OPASG2. OPASG2 provides benefits to employment and recruitment processes. - Occupational Health and the Well-being Service continue to work with Therapies colleagues on support for staff experiencing Long Covid-19. Support equality and diversity of workforce. - A part time Disability Inclusion Officer has been seconded to the EDI Team (December 2023 – December 2024). - Band 5 EDI Officer appointed and commence in post at the end of March 2024. - Inclusive Leadership sessions embedded in the Leading People Programme from January 2024 onwards. - Reverse Mentorship Programme launched February 2024. Other - Assessment of compliance against BMA Rest and Facilities charter complete with action plan developed, reporting to LNC - Reducing fatigue poster developed.	Occupational Health. - Reviewed Occupational Health provision and consider options to improve sustainability within the service, paper drafted. - Submission of response to All Wales KPI delivery and ongoing data analysis review in place. - Recently appointed 8a role to provide further clinical leadership and key priority for M1-3 is to undertake training needs analysis to develop OH team. Support equality and diversity of workforce. - Review of staff diversity networks. - Review of wellbeing survey through and equality lens to understand variations within diverse workforce demographic profile. - Development of a buddy system to assist international medical staff with induction and orientation and support values and current norms. - Development of an empowerment passport to support disabled staff and reasonable adjustments and wellbeing.			

RISK THEME	PEOPLE				
Strategic Risk - SRR 001	The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.			Publication Status	Public
Strategic Threat	c) Due to insufficient and ineffective leadership levels throughout the organisation			Risk Appetite Level – Open Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	➤ Adverse impacts on delivery of care to patients across acute and non-acute settings; ➤ Failure to deliver health board priorities, required improvements and achieve sustainability; ➤ Poor levels of accountability and delivery; ➤ Reputational damage to the health board as an employer; ➤ Adverse impacts on staff recruitment and retention			Risk Appetite Threshold - Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.	
				SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
Lead Director	Director of Workforce & Organisational Development	Risk Exposure	Current Level	Target Level	
Monitoring Committee	People & Culture Committee	Likelihood	3 <i>(Possible)</i> x	3 <i>(Possible)</i> x	
Initial Date of Assessment	01 June 2023	Impact	4 <i>(Major)</i>	2 <i>(Minor)</i>	
Last Reviewed	01 July 2024	Risk rating	= 12 <i>(High)</i>	= 6 <i>(Moderate)</i>	
Next Review Due Quarterly based on current score	01 October 2024				

Key Controls (What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control (Are further controls possible to reduce risk exposure within tolerable range?)	Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective)	Gaps in Assurance/ Actions to Address Gaps (Insufficient evidence as to the effectiveness of the controls or negative assurance)	Assurance Rating (Overall Assessment)
Talent and Succession Planning - Monitoring Framework to support roll out of the People Plan - focus on Talent and Succession Planning. - Monitoring frameworks with HEIW. - Lead appointed in July 2023 on a secondment funded by HEIW to create an organisational talent management framework to enable the organisation to deliberate and consistently attract, identify, and develop talent for critical roles across ABUHB. - HEIW schemes 1 x HEIW funded graduate management trainee successfully appointed August 2023 following additional recruitment process. Development leadership capabilities - Leadership journey and programmes mapped and 1 pager flyer designed & on intranet. Leadership development offer now available for entry level leaders and managers, Clinical Directors, Directorate Manager development programme (DMx) launched in Q1 2024/25, Senior Nurses and multi-disciplinary teams. - Learning Masterclasses have been designed and developed for the organisation addressing key themes such as giving feedback, developing teams, and having courageous conversations. - Leading People Programme started May 2024. 2022/2024 Academi Wales scheme the Health Board are sharing a graduate with Monmouthshire Council. The Graduate joined the Health Board in March 2023 and is supporting the decarbonisation agenda. A further management graduate is due to start in September 2024, commencing rotation in Workforce and Organisational Development.	Talent and Succession Planning - Talent management and succession planning framework signed off by Executive Committee - SharePoint site development with a suite of resources to support colleagues and managers 1 day training on holding career conversations and succession planning with 100 spaces over the next 5 months. Development leadership capabilities - Currently exploring leadership funding options with USW in order to maximise Governmental Grants and utilisation of the apprentice levy. - Continued commitment to NHS graduate schemes. Values and Behaviour Framework - As part of the HB's 10-year strategy development we are involving colleagues in evolving our values and behaviours which will include all staff including those in leadership roles. We have four ways colleagues can get involved from spending 2mins scanning a QR code to attending a 90min in person session.	Level 1 Operational (Implemented by the department that performs daily operation activities) - WOD Divisional reporting - Evaluation of internal leadership programmes and regular review of our internal offer Level 2 Organisational (Executed by risk management and compliance functions.) - Reporting to People and Culture Committee - progress against People Plan 22-25 Level 3 Independent (Implemented by both auditors internal and external independent bodies.) - Internal Audit Review - Talent and Succession Board	Gaps in Assurance Action to Address Gaps in Assurance	Positive Assurance

RISK THEME	PEOPLE				
Strategic Risk - SRR 001	The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.			Publication Status	Public
Strategic Threat	d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level			Risk Appetite Level – Open Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	➤ Adverse impacts on delivery of care to patients across acute and non-acute settings ➤ Non-compliance with safe staffing principles and standards ➤ Litigation & Financial Penalties ➤ Reputational damage to the health board and loss of public confidence			Risk Appetite Threshold – Open Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.	
				SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
Lead Director	Director of Workforce & Organisational Development	Risk Exposure	Current Level	Target Level	
Monitoring Committee	People & Culture Committee	Likelihood	3 <i>(Possible)</i> x	2 <i>(Unlikely)</i> x	
Initial Date of Assessment	01 June 2023	Impact	4 <i>(Major)</i>	4 <i>(Major)</i>	
Last Reviewed	01 July 2024	Risk rating	= 12 <i>(High)</i>	= 8 <i>(Moderate)</i>	
Next Review Due Quarterly based on current score	01 October 2024				

Key Controls <i>(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>(Are further controls possible to reduce risk exposure within tolerable range?)</i>	Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance/ Actions to Address Gaps <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Assurance Rating <i>(Overall Assessment)</i>
- All Wales Industrial Action Planning Group - Local Health Board planning arrangements - Section 234A of the Trade Union and Labour Relations (Consolidation) Act 1992; and - CODE OF PRACTICE Industrial Action Ballots and Notice to Employers - Business Continuity Processes - Redeployment Principles and Risk Assessment agreed. - Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture - Effective derogation processes including Christmas Day cover definition. - Local Negotiating Committee (LNC) - Services Business continuity plans in place. - Terms and conditions agreements in place for medical cover supported by NHS Wales Employer guidance. - Command and control structure and leads established. - Derogation test completed. - Executive and Senior Manager leads established links with national planning cells. - All Wales training sessions provide by legal and risk to support industrial action. - Reducing impact on patients - Support for early supported discharge prior to industrial action. - Picketing guidance supported and agreed	- Agreement reached in England for Medical & Dental Staff – re-commencement of negotiations in Wales for Medical & Dental Staff. - Issue of WHC AFC non pay elements of collective agreement 2022-24. Responded to WG on immediate assurance in May and an update provided in July 2024 on the progress within the Health Board on implementation. - Review of rotas for junior doctor industrial action (minimum staffing levels based on safety assessment). - Communication plans - public, stakeholders and partners. - Establish working mechanisms with NWSSP to consider derogations for junior doctors (who are the employer) and pay application. - Consideration of further additional national legal advice. - Awaiting confirmation of Agenda for Change Pay Award 2024/25 and at which point this risk will be reviewed.	Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>	Gaps in Assurance Further industrial action	Reasonable Assurance
		- Local Staff re-deployments assessment - Divisional engagement and service planning arrangements in place - Local Negotiating Committee (LNC) - Trade Union Partnership meetings		
		Level 2 Organisational <i>(Executed by risk management and compliance functions.)</i> - Reporting to Executive team - Business Continuity groups - Command and control structure in place to be implemented as required.	Action to Address Gaps in Assurance	
		Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies.)</i> - All Wales IA group and Welsh Government planning group. - Debriefing session planned to reflect and capture learning for any potential future action		

RISK THEME	SERVICE DELIVERY					
Strategic Risk: SRR 001	There is a risk that the Health Board will be unable to deliver and maintain high quality, safe and sustainable services which meet the changing needs of the population.				Publication Status	Public
Strategic Threat	e) Due to inadequate strategic plans which respond to population health and socio-economic needs.				Risk Appetite Level - OPEN Willing to consider all potential options, subject to continued application and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	➤ Increased demand ➤ Increased patient acuity levels ➤ Worsening of health inequalities ➤ Worsening of health outcomes ➤ Failure to train teams in multi-morbidity management ➤ Failure to comply with the Wellbeing of Future Generations Act (Wales) ➤ Reputational damage and loss of public confidence				Risk Tolerance Level - OPEN SCORE 17 AND BELOW Risks relating to all aspects of our ability to deliver, manage and improve service quality and performance along with all relating risks relating to the current performance of our infrastructure such as IM&T and estates including our ability to deliver associated strategy.	
					SUMMARY The current risk level is OUTSIDE of target level but WITHIN the set appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
Lead Director	Director of Strategy, Planning and Partnerships.	Risk Exposure	Current Level	Target Level		
Monitoring Committee	Partnerships, Public Health & Planning Committee	Likelihood	2 (Unlikely)	2 (Unlikely) x		
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	3 (Moderate)		
Last Reviewed	01 August 2024	Risk rating	= 8 (Moderate)	= 6 (Moderate)		
Next Review Due Bi-annually based on current score	01 November 2024					

Key Controls <i>(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>(Are further controls possible to reduce risk exposure within tolerable range?)</i>	Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance/ Actions to Address Gaps <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Assurance Rating <i>(Overall Assessment)</i>
• Health Board IMTP and associated KPIs • Public Health Wales surveillance data • Qliksense – performance dashboard • Population Needs Assessment and Area Plan • Marmot Region Programme • System level linked pathway data using SFN Platform	• Area plan is being refreshed through the RPB • Marmot Region Implementation Plan • Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. • Refresh organisational strategy with a central focus on population health and wellbeing. • Action through SEW Regional Collaborative to identify additional service areas where collaboration and networking would support sustainability.	Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>	Gaps in Assurance	Reasonable Assurance
		• Qliksense – performance information • SFN – Pathway performance information and at system level	• Effectiveness of the plans in delivering improvements	
		Level 2 Organisational <i>(Executed by risk management and compliance functions.)</i>	Action to Address Gaps in Assurance	
		• IMTP Delivery and Outcomes Reporting to Board • Marmot Region Programme • RPB reporting to Board and Population Health, Planning and Partnerships Committee • Regional Planning reporting to Population Health, Planning and Partnerships Committee • Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee	• Outcome of the Internal Audit Partnership Arrangements scheduled for Q1 2024/25 Plan	
		Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies.)</i>		
		Internal Audit Reviews 2023-24		
		1. IMTP Planning (Q1) Outcome – Reasonable Assurance		

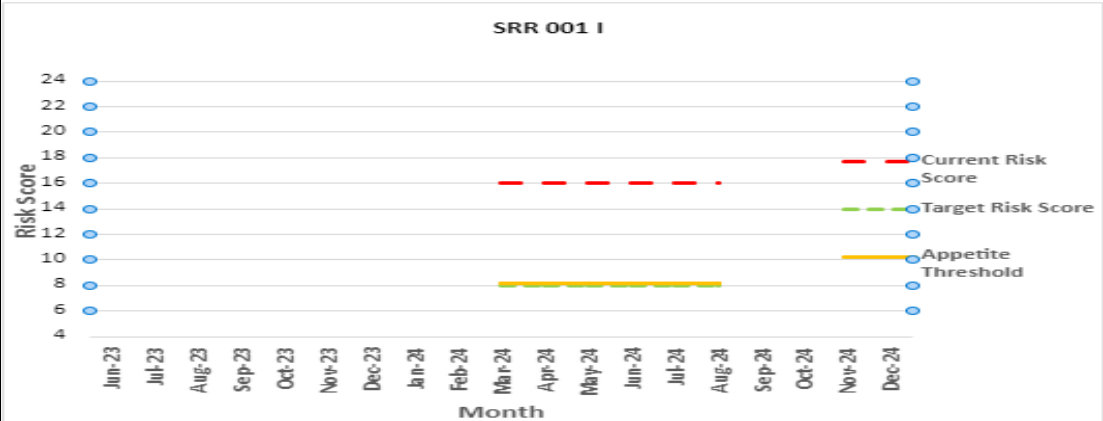
RISK THEME	SERVICE DELIVERY				
Strategic Risk: SRR 001	There is a risk that the Health Board will be unable to deliver and maintain high quality, safe and sustainable services which meet the changing needs of the population.			Publication Status	Public
Strategic Threat	f) Due to unsustainable service models			Risk Appetite Level - OPEN Willing to consider all potential options, subject to continued application and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	➤ Harm or injury to patients and/or staff ➤ Adverse impacts on delivery of care to patients across acute and non-acute settings ➤ Increased demand ➤ Increased patient acuity levels ➤ Worsening of health inequalities ➤ Worsening of health outcomes ➤ Failure to deliver health board priorities, required improvements and achieve sustainability ➤ Reputational damage and loss of public confidence			Risk Tolerance Level - OPEN SCORE 17 AND BELOW Risks relating to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and estates including our ability to deliver associated strategy.	
				SUMMARY The current risk level is OUTSIDE of target level but WITHIN the set appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
Lead Director	Director of Strategy, Planning and Partnerships.	Risk Exposure	Current Level	Target Level	
Monitoring Committee	Partnerships, Public Health & Planning Committee	Likelihood	3 (Possible) x	2 (Unlikely) x	
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	4 (Major)	
Last Reviewed	01 August 2024	Risk rating	= 12 (High)	= 8 (Moderate)	
Next Review Due Quarterly based on current score	01 November 2024				

Key Controls (What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control (Are further controls possible to reduce risk exposure within tolerable range?)	Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective)	Gaps in Assurance/ Actions to Address Gaps (Insufficient evidence as to the effectiveness of the controls or negative assurance)	Assurance Rating (Overall Assessment)
- Development of new long-term strategy - The Health Board IMPT and associated KPIs - Clinical Futures Transformation programmes. - Public Health Wales surveillance data – Covid, flu and other communicable diseases. - QlikSense – performance information. - Population needs assessment and area plan development by the RPB. - Southeast Wales Plan for fragile services.	- Area plan is being refreshed through the RPB. - Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. - Review of enhanced local general hospital service models to ensure sustainable quality services. - Development of SEW plan for fragile. - Review of organisational strategy – to launch Summer 2024.	Level 1 Operational (Implemented by the department that performs daily operation activities) - Public Health Wales surveillance data – JSNA - QlikSense – performance information.	Gaps in Assurance Evidence of individual arrangements in place to deliver service plans.	Reasonable Assurance
		Level 2 Organisational (Executed by risk management and compliance functions.) - IMTP delivery and outcomes reporting to Board. - RPB reporting to Board and Population Health, Planning and Partnerships Committee. - Regional Planning reporting to Population Health, Planning and Partnerships Committee. - Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee.	Action to Address Gaps in Assurance Recommendations from the Internal Audit of IMTP – Service Plans (Q2)	
		Level 3 Independent (Implemented by both auditors internal and external independent bodies.)		
		Internal Audit Reviews 2023-24 1. IMTP planning Q1. Outcome – Reasonable Assurance. Internal Audit Reviews 2024-25 2. IMTP – Service Plans (Q2)		

RISK THEME	FINANCIAL SUSTAINABILITY				
Strategic Risk: SRR 001	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.			Publication Status	Public
Strategic Threat	g) Due to the failure to deliver a sustainable financial position and longer-term financial plan.			Risk Appetite Level - Cautious. Preference for safe, though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls.	
Impact	➤ Breach of statutory duty to breakeven over 3 years. ➤ Instigation of NHS Wales Escalation & Intervention Arrangements. ➤ Non–delivery of health board priorities, required improvements, and achieving longer-term sustainability. ➤ Prioritisation and possible disinvestment in service delivery. ➤ Reputational damage and loss of public confidence			Risk Appetite Threshold - Score 13 and below Risks relating to all aspects of our financial performance and our ability to manage cost and efficiencies.	
				SUMMARY The current risk level is OUTSIDE of the target and appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
Lead Director	Director of Finance and Procurement	Risk Exposure	Current Level	Target	SRR 001G Risk Score 24 22 20 18 16 14 12 10 8 6 4 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Month Current Risk Score Target Risk Score Appetite Threshold
Monitoring Committee	Finance & Performance Committee	Likelihood	5 <i>(Almost certain)</i> X	2 <i>(Unlikely)</i> X	
Initial Date of Assessment	01 June 2023	Impact	4 <i>(Major)</i>	4 <i>(Major)</i>	
Last Reviewed	07 August 2024	Risk rating	= 20 <i>(Extreme)</i>	= 8 <i>(Moderate)</i>	
Next Review (Monthly based on current risk score)	07 September 2024				

Key Controls <i>(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>(Are further controls possible to reduce risk exposure within tolerable range?)</i>	Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance/ Actions to Address Gaps <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Assurance Rating <i>(Overall Assessment)</i>
- IMTP 2023/24-25/26 - IMTP Delivery Framework - Accountability Framework - Performance Framework - Scheme of Delegation - Standing Financial Instructions (SFIs) - Standing Orders (SOs) - Final budget delegation - Financial Control Procedure (FCP) Budgetary control - Financial Budget Intelligence (FBI) - Appropriately trained Finance Team (capacity & capability) - Budget holder training - Cost intervention procedures 23/24 savings plans & opportunities. - Health Board financial escalation processes. - Health Board Pre-Investment Panel (PIP) process. - Financial assessment and review to incorporate the financial impact of COVID-19 and other key costs. - Executive groups and structures established to deliver statutory duties.	- Revised V&SB approach for 2024/25 to help drive financial recovery, separating thematic and divisional scrutiny. - Focus on future opportunity development to deliver 3-year financial plan – through programmes under the VS&B structure.	Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i> - Adherence to SO/SFI/FCPs - Regular AFD meetings to discuss position and performance. - Divisional Assurance meetings are in place to implement savings plans and deliver service and workforce plans within available resources – part of Chief Operating Officer governance.	Gaps in Assurance - Greater focus is required on service, workforce, and financial plans all balancing to achieve financial sustainability. - Development of detailed 3-year recovery plan.	Reasonable Assurance
		Level 2 Organisational <i>(Executed by risk management and compliance functions.)</i> - Regular monitoring at the Executive Team reviewing the level of deliverable recurrent savings along with assessing cost avoidance and deferred investments. - Performance escalation meetings established. - Financial assessment and review report to the Board and Finance & Performance Committee - Financial Governance and Accounting reports to the Audit, Risk and Assurance Committee. - Board Briefing sessions on the financial position.	Action to Address Gaps in Assurance 2024/25 IMTP plans focussed on ‘living within’ budget levels. 2024/25 savings plans to be delivered. - Detailed delivery plans will be a constant development over next 2 years.	
		Level 3 Independent		

- Assessment of financial control environment within divisions and corporate teams. - Financial Escalation Meetings - Regular organisational Recovery plan meetings and briefings - Value & Sustainability Board established. - Revised accountability arrangements part of Executive governance. 3-year route map to sustainable recovery developed and approved by Board July 24.		(Implemented by both auditors internal and external independent bodies.)		
		Internal Audit Reviews 2023 – 24 - Savings Programmes – Reported to ARAC - Reasonable Assurance - Financial Controls – Reported to ARAC July 2024 – Substantial Assurance - Asset Management Q3 – Reported to ARAC April 2024 - Reasonable Assurance External Audit Reports 2023 -24 - Efficiency Review 23/24 Q3/Q4 – Not yet reported. - Structured Assessment - Received at ARAC November 2023. - Audit of Financial Statements Q4 2023/24 – True & Fair view given, minor recommendations, qualified on deficit and 3-year IMTP not agreed. - Financial assessment and review reports to Welsh Government – monthly - Enhanced monitoring T.I. meetings with Welsh Government – monthly		

RISK THEME	COMPLIANCE AND SAFETY					
Strategic Risk: SRR 001	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services which meet the changing needs of the population				Publication Status	Public
Strategic Threat	i) Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.				Risk Appetite Level - MINIMAL Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.	
Impact	➤ Unintended patient harm ➤ Negative patient/public experience ➤ Loss of patient/public trust and confidence ➤ Reduced staff morale leading to potential absence from work ➤ Scrutiny from external organisations (AW/HIW/WG) ➤ Punitive Action ➤ Adverse publicity ➤ Financial implications				Risk Appetite Threshold – SCORE 8 AND BELOW Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.	
					SUMMARY The current risk level is OUTSIDE of target and the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
						
Lead Director	Director of Strategy, Planning & Partnerships	Risk Exposure	Current Level	Target Level		
Monitoring Committee	Finance and Performance Committee	Likelihood	4(Likely) X	2 (Unlikely) X		
Initial Date of Assessment	19 April 2024	Impact	4 (Major)	4 (Major)		
Last Reviewed	01 August 2024	Risk rating	= 16 (Extreme)	= 8 (Moderate)		
Next Review (Monthly based on current risk score)	01 November 2024					

Key Controls <i>(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>(Are further controls possible to reduce risk exposure within tolerable range?)</i>	Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance/ Actions to Address Gaps <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Assurance Rating <i>(Overall Assessment)</i>
Performance Management and Assurance Framework Executive Accountability letters Divisional Directors Accountability letters Monthly Assurance meetings with fortnightly meetings for Urgent Care and MH&LD Divisions in place Escalation processes triggered for Divisions in escalation – including improvement plans and fortnightly oversight (as above) with agendas that focus on priority areas. Reviewed post End of Year and proposed adjustments awaiting sign off Reporting through to Finance and Performance Committee via Executives Specific areas of focus are discussed at Value and Sustainability Board System wide way of working to progress an operational framework, develop winter plans, escalation processes, etc. External scrutiny via Welsh Government and NHS Executive	6-month review of Performance Management and Assurance Alignment of internal mechanisms to national escalation Focussed agendas targeting specific areas of concern and areas for improvement – working with the Business Partners to ensure a joined-up approach. Standardised Divisional Assurance Templates (pre-populated) Commission external reviews to support improvements where required. Appropriate Business Partnering Support and analytical support Realign capacity and/or redefine roles to provide explicit support	Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i> - DMTs in place for all Divisions - Divisional oversight arrangements – monthly/fortnightly meetings - Divisional plans in place and focussed agendas - Cross Divisional meeting monthly – progress the wider system way of working. - System Leadership Team for awareness and updates Level 2 Organisational <i>(Executed by risk management and compliance functions.)</i> - Established reporting to the Executive Committee - Established reporting to the Finance and Performance and Patient, Quality and Safety Committee - Established reporting to the Board - Routine reporting through the IQPD process Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies.)</i> - Internal Audit 2024/25 Plan - Directorate Review - Mental Health and Learning Disabilities (Q2) - Divisional Governance Arrangements (Q2) - HIW Inspections - Llais for feedback	Gaps in Assurance Capacity to run the performance framework and reporting requirements. If Business Partnering Support and analytical support is in the appropriate areas, will be reviewed as part of 12 month Performance Management Framework review in the Autumn Action to Address Gaps in Assurance Internal Audit 2024/25 Plan Findings and recommendations from the Divisional Governance Arrangements (Q2) Findings and recommendations from the Directorate Review - Mental Health and Learning Disabilities (Q2)	Reasonable Assurance

RISK THEME	COMPLIANCE AND SAFETY						
Strategic Risk: SRR 002	There is a risk that there will be significant failure of the Health Boards Estates.					Publication Status	Public
Strategic Threat	a) Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures.				Risk Appetite Level - MINIMAL Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.		
Impact	➤ Harm or injury to patients and/or staff. ➤ Adverse impacts on the delivery of care to patients across acute and non-acute settings. ➤ Non-compliance with health and safety legislation. ➤ Loss of estate ➤ Litigation and financial penalties				Risk Appetite Threshold - SCORE 8 AND BELOW Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.		
					SUMMARY The current risk level is OUTSIDE of the target level and appetite threshold. The target level to be achieved is WITHIN the set appetite threshold		
Lead Director	Chief Operating Officer	Risk Exposure	Current Level	Target Level	SRR 002 a) Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures <		

Key Controls (What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control (Are further controls possible to reduce risk exposure within tolerable range?)	Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective)	Gaps in Assurance/ Actions to Address Gaps (Insufficient evidence as to the effectiveness of the controls or negative assurance)	Assurance Rating (Overall Assessment)
• Work to assess the risk has been undertaken with expert external surveyor advice. Repeat surveys undertaken on 6 monthly intervals (most recent June 2023) • Current measures including props and additional support have been put in place in line with the latest guidance and learning from other organisations working through RAAC issues. Plans will be modified in line with any further guidance • Remediation work to areas of high-risk areas undertaken • Controlled access to roof areas • Implemented toolbox talks for awareness for estate teams and contractors to work in area where RAAC is present. • Ongoing engagement with expert surveyor • Estates and Facilities Divisional Compliance team engaged in supporting the estate's function response to the ongoing management • Risk assessments completed by the Health and Safety function in departments with props to manage any consequences of the presence of props. <i>Note: H&S assessments are around the location of props not of RAAC itself and they flagged no issues or alterations</i> • Links with NHS England and other Health Boards in Wales for shared learning. • Fortnightly dialogue with Welsh Government and Shared Services Estates.	• Additional Surveys continue to take place with expert surveyors to inform the next steps relating to further remediation of the issues and monitor existing issues • Review of existing arrangements to monitor, manage and mitigate issues associated with RAAC is underway with external support and advice from the surveying contractor based on their experiences in NHS England and education bodies. This will inform any additional steps to monitor manage and mitigate led by the RAAC Working Group (chaired by the Director of Estates and Facilities Division)	Level 1 Operational (Implemented by the department that performs daily operation activities)	Gaps in Assurance	Reasonable Assurance
		• Fortnightly checks in place for the props in place • Outcome of surveys continuing, and reinspection of conditions (a regular 6 monthly inspection) • Review of existing arrangements in place supported by external body	• Ongoing management of the issues.	
		Level 2 Organisational (Executed by risk management and compliance functions.)	Action to Address Gaps in Assurance	
		• Health Board Fire and Health and Safety function engaged in fortnightly governance group to monitor risks and issues associated with any remedial measures implemented. • Outcome of H&S risk assessment • Formal reporting to the Board • Formal update to the PPHPC in July with full SOC end of Q3.	• Repeat surveys have been completed and once the latest report from these surveys is received any necessary additional actions will be implements Internal Audit 2024/25 Plan • Nevill Hall RAAC (Q1) • Review of existing governance arrangements (reporting early Q2) – report being finalised by external advisors and will be received in August for review within ABUHB	
		Level 3 Independent (Implemented by both auditors internal and external independent bodies.)		
		Internal Audit 2024/25 Plan • Nevill Hall RAAC (Q1) – In progress		

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

Key Controls <i>(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>(Are further controls possible to reduce risk exposure within tolerable range?)</i>	Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance/ Actions to Address Gaps <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Assurance Rating <i>(Overall Assessment)</i>
- Health Board Estates Rationalisation Strategy - Health Board Estates Strategy - Health Board policies and procedures related to the maintenance of Health Board estate. 6 Facet survey completed in 2019. - Divisional Risk Register - Multiple policies and SOPs published and communicated to staff. - A robust internal training programme in place covering all aspects of estate management including food hygiene. - Improved statutory compliance processes and forum led by Designated Person - DP (Divisional Director) - Asbestos reinspection programme (over the next 3 years) - Additional capital allocation to Estates and Facilities for backlog maintenance reduction of £500k from discretionary allocation - HB-wide groups on compliance (such as Ventilation and water) are widened in membership to ensure clinical services are active participants - A clear approach to compliance monitoring and escalation of AE reports has been implemented.	- Active estate rationalisation (including leases) is required to reduce estate demands and help prioritise capital spend to reduce backlog maintenance. - A water/ventilation engineer to enable all critical ventilation systems to undergo annual validation in accordance with HTM 04/01. - Ongoing attempts to recruit to workforce gaps and a new model of Estate Officer also being developed to assist with recruitment and retention of staff in the workforce. - Planning function leading a review of capital priorities which may help identify additional funding priority given to backlog maintenance. - Policies being reviewed and priority given to out-of-date policies, but all policies will be reviewed for effectiveness and compliance with HTM. - Drive clinical service engagement in compliance meetings where engagement is low. - Additional escalation for capital funding by the Division Estates and Facilities to support the prevention of seasonal issues and plant failure if possible.	Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>	Gaps in Assurance	Reasonable Assurance
		- Divisional reporting of Statutory and Mandatory training of staff - Staff training levels are monitored and reported regularly. If areas of non-compliance are noted, targeted training can be resourced to ensure compliance. - Outcome of the Asbestos reinspection programme	If the revised approach for monitoring and escalation of AE reports is effective in reducing the level of a deterioration.	
		Level 2 Organisational <i>(Executed by risk management and compliance functions.)</i>	Action to Address Gaps in Assurance	
		- The divisional risk register is reviewed quarterly by the Senior Management Board this is reported to the Quality & Patient Safety Operational Group - Regular reporting on estate condition to the Executive Committee and Partnerships, Health Protection & Planning Committee	Performance reporting	
		Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies.)</i>		
		Internal Audit Reviews 2023- 24 Estates Assurance - Estate Condition. Audit completed and been shared with Audit Committee and Finance and Performance Committee		
		Internal Audit Plan 2024-25 Estates Assurance – Energy Management (Q4) - Authorising Engineer (Shared Service Estates) reports in line with normal timelines, but active engagement with AEs through compliance processes. - Health Board contributes to annual Estates Facilities and Performance Managements (EFPMS) at all Wales level		

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

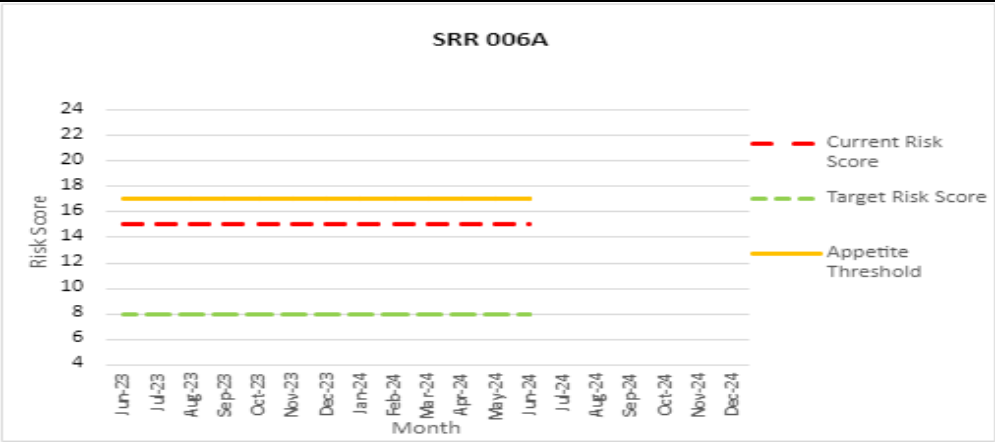
Key Controls <i>(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>(Are further controls possible to reduce risk exposure within tolerable range?)</i>	Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance/ Actions to Address Gaps <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Assurance Rating <i>(Overall Assessment)</i>
Major Incident - Major Incident Plan - Local/Divisional action cards are in place. - Training undertaken service-specific relating to local response. Business Continuity (BC) /Critical Incident - BC Policy - BC Response Guidance - BC Template - BC Exercise - BC debrief learning. - HB and LRF Plans. 3 C (Command/Control, Communication) structure in place to respond to incidents. - EPRR Group Established. - Repository on intranet for BC plans to be added to by areas for audit, maintenance, and review of interdependencies. - Awareness raising of the requirement for BC across the Health Board through various training programmes Infectious Diseases - Joint plan with PH in response to infectious diseases and public health incidence response. Overall - Internal strategic on call training	- Major Incident Exercise ‘Euclid’ planned for 20th June 2024 – Faculty in place to plan scope and detail of exercise. - Testing programme of business continuity plans. - Improved Engagement with Divisions, Directorates, and service areas to embed contingency planning in the culture of the organisation, Conduct BIAs develop plans, Exercise, review, to mitigate the risks and threats to service delivery. - Develop further training programmes to support staff preparedness to response to an incident. - Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Co-Ordination) structure of strategic, tactical, and Operational. - Work with the communication team to improve incident cascade during an event to ensure Health Board wide awareness in a timely manner. - Working with ICT to scope how to maintain critical communications during loss of IT linked telephone systems or national power	Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>	Gaps in Assurance	Reasonable Assurance
		Departmental debrief following an incident to inform learning and enhance controls.	Robustness of service business continuity plans within Divisions	
		Level 2 Organisational <i>(Executed by risk management and compliance functions.)</i>	Action to Address Gaps in Assurance	
		- Debrief with key stakeholders following an incident to inform learning and enhance controls. - Report to the EPRR Group from debrief of incidents - Reports to the PPHP Committee on Emergency Planning Preparedness	Recommendations for strengthening resilience following testing of service business continuity plans	
		Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies.)</i>		
		Internal Audit Review(s) - Business Continuity Planning 2023-24 (Q2) outcome report published – Reasonable Assurance - Outcome and feedback from national exercises		

• Executive Team attending 2-day strategic training. • Regular liaison with Gwent Local Resilience Forum (Strategic and tactical) • Joint Planning and Training with LRF and across Wales. • Ongoing Participation in exercises UK, Wales, LRF and HB. • Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP).	outages. (as this is not fully implemented, it is still being worked through thus would make it additional control until in place)			

RISK THEME	SERVICE DELIVERY					
Strategic Risk: SRR 005	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.				Publication Status	Public
Strategic Threat	Due to inadequate arrangements to support system-wide patient flow				Risk Appetite Level - Open Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	
Impact	➤ Avoidable deaths or significant harm ➤ Delays in releasing ambulances from hospital sites back into the community ➤ Delayed discharges from acute and non-acute settings resulting in deteriorating patients; ➤ Litigation & Financial Penalties ➤ Reputational damage and loss of public confidence				Risk Appetite Threshold – Open SCORE 17 AND BELOW Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.	
					SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
					SRR 005 a) Due to inadequate arrangements to support system wide patient flow.	

Key Controls (What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control (Are further controls possible to reduce risk exposure within tolerable range?)	Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective)	Gaps in Assurance/ Actions to Address Gaps (Insufficient evidence as to the effectiveness of the controls or negative assurance)	Assurance Rating (Overall Assessment)
- Escalation Policy. - Performance and Accountability Framework - Major incident Procedures - Daily X-site flow meetings - Twice daily flow calls to receive updates from all acute sites as well as community services. Allowing opportunity for escalation of risks. - Escalation communications – ambulance focussed email escalation when congestion begins to build up on the GUH forecourt. Aim to escalate to senior management to aid in quick risk-based decision making. Includes members of the Executive team. - fortnightly safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Action focussed and task driven. - Enhanced monitoring in place for U&EC - Range of performance measures/metrics in place - Repatriation mechanism with neighbouring Health boards – Daily repatriation calls between head of operations and counterparts in south Wales to ensure regular dialogue to repeat patients between hospitals and health boards. - Maximum Capacity Plan – Executive team agreed maximum capacity plan to ensure there is clear description ad guide for where extra capacity can be accessed to ensure patient flow is maintained. - Planned care recovery meetings with the NHS execs. - Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls. - WG – IQPD meetings to review areas of focus.	Operational framework – Being revamped through operational framework ahead of next winter. Improve regional acceptance of flow processes with neighbouring Health Boards. Repatriation meetings established and new Wales-wide protocols due to come in regarding repatriation.	Level 1 Operational (Implemented by the department that performs daily operation activities) The Escalation Framework has been enacted and is effective in mitigating threats and impact to services. Performance report against measures/metrics	Gaps in Assurance Evidence that the Escalation Framework is delivering improvements across all areas of patient flow e.g., ambulance handovers. Now working to KPI WG plan. The impact of the Performance and Accountability framework in improving patient flow	Reasonable Assurance
		Level 2 Organisational (Executed by risk management and compliance functions.) Divisional Assurance reviews. Performance against measures/metrics reported to the Executive Committee	Action to Address Gaps in Assurance Close monitoring and reporting of the frameworks in practice to support learning and improvements.	
		Level 3 Independent (Implemented by both auditors internal and external independent bodies.) Internal Audit Reviews 1. Intra-site Patient Transfers – Reasonable Assurance accepted by the ARAC on 9 th July 2024.		
		External inspections/visits.		

RISK THEME	SERVICE DELIVERY			
Strategic Risk: SRR 006	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.			Publication Status Public
Strategic Threat	a) Due to the full or partial failure of existing digital infrastructure and systems.			Risk Appetite Level - OPEN Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.
Impact	- Harm or injury to patients and/or staff - Adverse impacts on delivery of care to patients across acute and non-acute settings - Data breaches - Litigation & Financial Penalties - Reputational damage and loss of public confidence			Risk Appetite Threshold - Score 17 and below Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy. SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
Lead Director	Director of Digital	Risk Exposure	Current Level	Target Level
Monitoring Committee	Finance & Performance Committee	Likelihood	3 (Possible) X	2 (Unlikely) X
Initial Date of Assessment	01 June 2023	Impact	5 (Catastrophic)	4 (Major)
Last Reviewed	01 June 2024	Risk rating	= 15 (Extreme))	= 8 (Moderate)
Next Review Due (Quarterly based on current risk score)	01 July 2024			



Key Controls (What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control (Are further controls possible to reduce risk exposure within tolerable range?)	Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective)	Gaps in Assurance/ Actions to Address Gaps (Insufficient evidence as to the effectiveness of the controls or negative assurance)	Assurance Rating (Overall Assessment)
Remedial Action Plan revised and updated to capture further recommendations against NIS CAF assessment in Jan 2024. This Action Plan has also supported ABUHB risk remediation responses to ABUHB's NIS CAF Risk Register which by CRU to address risks identified during the NIS CAF assessment. The remedial actions proposed have been accepted by CRU and progress will be reviewed annually. Director of Digital (SIRO) and Chief Information Officer (Deputy SIRO) SIRO trained. New Information Governance and Cyber Security governance and assurance processes reviewed and implemented. Governance group terms of reference agreed. Meetings started in November 2023. Cyber is fully engaged with IG colleagues to implement the recommendations of the Templar report. Cyber now supports all the Governance and Assurance Groups intending to increase cyber security awareness and build cyberculture amongst non-ICT staff Scheduled monthly vulnerability scans of all ABUHB-managed servers to include third-party servers. The results of these scans will now be reported in the Monthly Cyber Report.	Implement the recommendations from Templar report: Work with Information Governance around implementing the controls required to achieve ISO27001 accreditation. A recent cyber incident at several London Hospitals presented an opportunity for ABUHB to battle test its cyber response, communication cascade and reporting to Cyber Resilience Unit. This will be incorporated into the overall action plan.	Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>	Gaps in Assurance	Reasonable assurance
		Internal directorate meetings setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans.	Oversight from NHS Wales Cyber Resilience Unit.	
		Level 2 Organisational <i>(Executed by risk management and compliance functions.)</i>	Action to Address Gaps in Assurance	
		Regular reporting on progress to the Finance & Performance Committee on the cyber security action plan.	An assessment against CAF was undertaken by CRU in January '24 and the report along with its recommendations has been circulated to key stakeholders.	
		Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies.)</i>		
		Cyber security Audit in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. Internal Audit 2024/25 Technical Continuity – planned for Q3		

Working with Business Systems and Desktop Teams to ensure that patching compliance for internally managed systems and third-party systems is monitored and reported monthly. Monthly review meetings are held between Cyber, and the Teams review compliance levels against policy. Results are captured within the monthly Cyber Report. Implement the recommendations from Templar report: Work with Information Governance around implementing the controls required to achieve ISO27001 accreditation. Battle tested OUR cyber incident response, communication cascade and reporting to Cyber Resilience Unit. This will be incorporated into the overall action plan. Working with ICT Support Teams and the Log4j version 2 vulnerability has been resolved within the Health Board. The least important service impacting Version 1 is being managed through ICT Departmental risk management process. · Risk impact reduced as recent loss of power at key sites, incorporating our data Centre allowed is to failover in a seamless fashion from one DC to the other with no service impact. · Maintained the use of Trust ware for all emails Trustwave provides inspection and protection from malicious links embedded within emails. · Begun the roll out simulated phishing campaigns. The initial phishing has been tested on the ICT Department and reported within the Cyber Report. Cyber will continue campaigns during 2023 to increase email security awareness among staff. · Introduced scenario-based incident response exercising using National Cyber Security Centre developed ‘Exercise in a box’ the aim is to assess our current skills in responding to real-life cyber security incident scenarios and to identify improvements. Cyber plans to run several more exercises during 2023.				

RISK THEME	SERVICE DELIVERY					
Strategic Risk: SRR 006	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.				Publication Status	Public
Strategic Threat	b) Due to an adverse impact on service delivery in the implementation of the new digital systems.			Risk Appetite Level - OPEN Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.		
Impact	➤ Harm or injury to patients and/or staff ➤ Adverse impacts on delivery of care to patients across acute and non-acute settings ➤ Data breaches ➤ Litigation & Financial Penalties ➤ Reputational damage and loss of public confidence			Risk Appetite Threshold - Score 17 and below Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.		
				SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold		
Lead Director	Director of Digital	Risk Exposure	Current Level	Target Level	SRR 006B 24 22 20 18 16 14 12 10 8 6 4 Jun-23Jul-23Aug-23Sep-23Oct-23Nov-23Dec-23Jan-24Feb-24Mar-24Apr-24May-24Jun-24Jul-24Aug-24Sep-24Oct-24Nov-24Dec-24 Risk Score Month Current Risk Score Target Risk Score Appetite Threshold	
Monitoring Committee	Finance & Performance Committee	Likelihood	3 <i>(Possible)</i> X	2 <i>(Unlikely)</i> X		
Initial Date of Assessment	01 June 2023	Impact	4 <i>(Major)</i>	4 <i>(Major)</i>		
Last Reviewed	01 August 2024	Risk rating	= 12 <i>(High)</i>	= 8 <i>(Moderate)</i>		
Next Review Due (Quarterly based on current risk score)	01 November 2024					

Key Controls <i>(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>(Are further controls possible to reduce risk exposure within tolerable range?)</i>	Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance/ Actions to Address Gaps <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Assurance Rating <i>(Overall Assessment)</i>
- Adoption of formal project management methodologies PRINCE 2 to ensure project plans are developed in conjunction with services. - Formal governance arrangements in place through project boards and programme boards where risks and issues are managed and mitigated. - Each project has a senior responsible officer from the service who can provide challenge and assurance over the delivery of the project work packages. - Each clinical project has a clinical lead who would advise and support potential impacts on service delivery caused by the implementation of new digital services. - Business change team in place to support services in improvement of clinical and administrative processes. - Benefits team in place who identify, track, and ensure any benefits are realised which will ultimately improve service delivery. - Projects support backfilling of clinical time where required. - Assurance activities included in project framework including clinical safety, information governance, health records and cyber security. - An overarching Digital Portfolio Progress Group is in place to receive programme updates, manage risk and issue escalations and provide multi-disciplinary assurance over digital projects.	Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee	Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>	Gaps in Assurance	Reasonable assurance
		- Internal directorate meetings setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. - Project Boards meet monthly and report into the quarterly Digital Portfolio Progress Group - Digital Directorate meetings being held monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. - Risk management approach and escalation processes in place in line with the Health Board’s Risk Framework	Uncertainty of where work programmes are reported and how progress is measured	
		Level 2 Organisational <i>(Executed by risk management and compliance functions.)</i>	Action to Address Gaps in Assurance	
		Regular Reporting to the Finance & Performance Committee	Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee	
		Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies.)</i>		

• Business change work includes a service readiness impact assessment to enable the project team to develop a realistic plan that incorporates service change requirements. • Aggregated view of risks and issues available to pick up common themes and impact for early intervention or escalation. • Aggregated view of digital Lessons Learned available and lessons are reviewed during project initiation for best chance of success. • Information Governance Sub Committee and Cyber Security Subgroup established		• Cyber security Audit in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. Internal Audit 2023/24 • Benefits Management review – Outcome Substantial Assurance • Stakeholder Engagement on IT Projects 2023/24 Q3 – Outcome Substantial Assurance Internal Audit 2024/25 • Implementation of the Welsh Intensive Care System – planned for Q1		

RISK THEME	SERVICE DELIVERY					
Strategic Risk: SRR 006	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.				Publication Status	Public
Strategic Threat	c) Due to failure to develop digital solutions that are sustainable and fit for the future.				Risk Appetite Level – OPEN Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	➤ Harm or injury to patients and/or staff ➤ Adverse impacts on delivery of care to patients across acute and non-acute settings ➤ Data breaches ➤ Litigation & Financial Penalties ➤ Reputational damage and loss of public confidence				Risk Appetite Threshold - Score 17 and below Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.	
					SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold	
Lead Director	Director of Digital	Risk Exposure	Current Level	Target Level	SRR 006 C Current Risk Score Target Risk Score Appetite Threshold	
Monitoring Committee	Finance & Performance Committee	Likelihood	3 <i>(Possible)</i> X	2 <i>(Unlikely)</i> X		
Initial Date of Assessment	01 June 2023	Impact	4 <i>(Major)</i>	4 <i>(Major)</i>		
Last Reviewed	01 August 2024	Risk rating	= 12 (High)	= 8 <i>(Moderate)</i>		
Next Review Due (Quarterly based on current risk score)	01 November 2024					

Key Controls <i>(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>(Are further controls possible to reduce risk exposure within tolerable range?)</i>	Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance/ Actions to Address Gaps <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Assurance Rating <i>(Overall Assessment)</i>
- New Digital Service Request process in place which provides governance in several key areas: - Automation of request process via ‘Seren’ the ICT Portal - Information Governance – ensuring new services have appropriate controls to keep patient information safe. - Cyber Security – ensuring new services adopted or developed meet the requirements of the cyber assessment framework. - Patient Safety – ensuring services do not introduce any patient safety risks. - Records – ensuring new systems comply with the requirements of records management. - Strong business analysis function in operation which ensures the “as-is” and “to-be” process mapping is undertaken which provides assurance that new services implemented are fit for purpose and delivery what stakeholders require. - Business change function which ensures implemented systems are effective and deliver the benefits required. - Formal framework in place for the adoption of new digital services and best practice guidance followed. - Annual planning processes include formal DDAT Annual Operational Plan aligned with service priorities identified in IMTP process	- Monthly/quarterly Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities to be arranged for MH & LD, Division of Medicine, Urgent Care & Families & Therapies - Portfolio optimisation to ensure the resources of the service are aligned to key priorities - New Digital Request quarterly reporting to DDAT sub-committee - New governance structures to be put in place further to directorate restructuring - Development of product management approach to delivery of core software applications and extending use of agile processes to ICT	Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>	Gaps in Assurance	Reasonable assurance
		Quarterly reporting to DDAT sub-committee	- If the NDSR process delivers anticipated improvements - The outcome of the EDRMS audit	
		Level 2 Organisational <i>(Executed by risk management and compliance functions.)</i>	Action to Address Gaps in Assurance	
		Regular Reporting to the Finance & Performance Committee	- Monitor the performance of the NDSR process - Audit into the effectiveness and appropriateness of the electronic document and records management solution (EDRMS) in use for the management of digital health records and the provision of scanning services.	
		Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies.)</i>		
		Cyber security in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems.		
		Internal Audit 2023/24		
		- LINC Programme– Outcome Reasonable assurance - Network Infrastructure (VPN) - Outcome Reasonable assurance		
		Internal Audit 2024/25		

○ New Digital Request processes include fortnightly senior leadership scrutiny of requests, • New prioritisation framework & tool Monthly/quarterly Operational delivery aligned to ITIL standards • Annual operational plan completed and aligned with IMTP • Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities for CSS Divisions of Surgery & PCCS in place • Software Development uses an agile product management methodology using DevOps software for managing its backlog, delivery plan and sprints		• Electronic document and records management solution - planned for Q4		

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING																																																																																				
Strategic Risk: SRR 007	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population.			Publication Status	Public																																																																																
Strategic Threat	a) Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.			Risk Appetite Level - OPEN Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.																																																																																	
Impact	➤ Unmet patient need resulting in harm ➤ Ineffective use of combined resources ➤ Delayed decision making ➤ Adverse impacts on delivery of care to patients across acute and non-acute settings ➤ Failure to deliver health board priorities, required improvements and achieve longer-term sustainability ➤ Reputational damage and loss of public confidence			Risk Appetite Threshold - SCORE 17 AND BELOW All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.																																																																																	
				SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.																																																																																	
Lead Director	Director of Strategy, Planning, and Partnerships.	Risk Exposure	Current Level	Target Level	SRR 007 A <table><thead><tr><th>Month</th><th>Current Risk Score</th><th>Target Risk Score</th><th>Appetite Threshold</th></tr></thead><tbody><tr><td>Jun-23</td><td>17</td><td>17</td><td>8</td></tr><tr><td>Jul-23</td><td>17</td><td>17</td><td>8</td></tr><tr><td>Aug-23</td><td>17</td><td>17</td><td>8</td></tr><tr><td>Sep-23</td><td>17</td><td>17</td><td>8</td></tr><tr><td>Oct-23</td><td>17</td><td>17</td><td>8</td></tr><tr><td>Nov-23</td><td>17</td><td>17</td><td>8</td></tr><tr><td>Dec-23</td><td>17</td><td>17</td><td>8</td></tr><tr><td>Jan-24</td><td>17</td><td>17</td><td>8</td></tr><tr><td>Feb-24</td><td>17</td><td>17</td><td>8</td></tr><tr><td>Mar-24</td><td>17</td><td>17</td><td>8</td></tr><tr><td>Apr-24</td><td>17</td><td>17</td><td>8</td></tr><tr><td>May-24</td><td>17</td><td>17</td><td>8</td></tr><tr><td>Jun-24</td><td>17</td><td>17</td><td>8</td></tr><tr><td>Jul-24</td><td>17</td><td>17</td><td>8</td></tr><tr><td>Aug-24</td><td>17</td><td>17</td><td>8</td></tr><tr><td>Sep-24</td><td>17</td><td>17</td><td>8</td></tr><tr><td>Oct-24</td><td>17</td><td>17</td><td>8</td></tr><tr><td>Nov-24</td><td>17</td><td>17</td><td>8</td></tr><tr><td>Dec-24</td><td>17</td><td>17</td><td>8</td></tr></tbody></table>	Month	Current Risk Score	Target Risk Score	Appetite Threshold	Jun-23	17	17	8	Jul-23	17	17	8	Aug-23	17	17	8	Sep-23	17	17	8	Oct-23	17	17	8	Nov-23	17	17	8	Dec-23	17	17	8	Jan-24	17	17	8	Feb-24	17	17	8	Mar-24	17	17	8	Apr-24	17	17	8	May-24	17	17	8	Jun-24	17	17	8	Jul-24	17	17	8	Aug-24	17	17	8	Sep-24	17	17	8	Oct-24	17	17	8	Nov-24	17	17	8	Dec-24	17	17	8
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Key Controls <i>(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>(Are further controls possible to reduce risk exposure within tolerable range?)</i>	Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance/ Actions to Address Gaps <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Assurance Rating <i>(Overall Assessment)</i>
The Health Board plays an active role in a range of formal partnership arrangements to enable integrated working for the population including: The Gwent Public Services Board (Gwent PSB) brings public bodies together to work to improve the economic, social, environmental, and cultural well-being in Gwent. They are responsible, under the Wellbeing of Future Generations (Wales) Act, for overseeing the development of the new Local Wellbeing Plan which is a long-term vision for the area. The Gwent Regional Partnership Board As set out in the Partnership Arrangements (Wales) Regulations 2015, local authorities and local health boards (RPB) manage and develop services to secure strategic planning and partnership working. RPBs also need to ensure effective services and care, and support is in place to best meet the needs of their respective population. Through these statutory forums formal partnership arrangements take place. In addition to these statutory forums the Health Board has a range of interfaces with key stakeholder bodies, including regular liaison with local authorities, neighbouring Health Boards, housing associations, and third-sector partners. Joint working between operational teams including integrated operational arrangements and combined multidisciplinary teams, for example, Community Resource Teams	- Governance review of Regional Partnership Board undertaken in August 2023. - Renewed Strategy for strategic partnership Capital in place and revised governance processes. - New Long-Term Strategy for Health Board to focus on Partnership approach.	Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i> - PMO reporting to the Director of Strategy, Planning and Partnerships. - Regional Leadership Group Reporting	Gaps in Assurance - Systematic reporting of outcomes - Systematic evaluation of schemes - Governance of financial control arrangements	Reasonable Assurance
		Level 2 Organisational <i>(Executed by risk management and compliance functions.)</i> - Assurance reporting to the Population Health, Partnerships, and Planning Committee. - Assurance reporting to the Board.	Action to Address Gaps in Assurance - Implementation plan to be developed following RPB governance review. - Health Board strategy development approach to focus on partnership approach.	
		Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies.)</i>		
		Internal Audit Plan 2023/24 RPB Governance Review (Q2) – due to be reported to the Audit, Risk & Assurance Committee in July 2024.		

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING					
Strategic Risk: SRR 008	There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.				Publication Status	Public
Strategic Threat	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.				Risk Appetite Level – Open Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure	
Impact	➤ Adverse impact on patient experience ➤ Failure to deliver health board priorities, required improvements and achieve longer-term sustainability ➤ Reputational damage and loss of public confidence ➤ Failure to deliver Duty of Quality				Risk Appetite Threshold – Open SCORE 17 AND BELOW All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.	
					SUMMARY The current risk level is OUTSIDE of target but WITHIN the appetite threshold. Target level is WITHIN the set appetite threshold.	
					Strategic Risk SRR 008 	
Lead Director	Director of Nursing	Risk Exposure	Current Level	Target Level		
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	Likelihood	2 (Unlikely) x	2 (Unlikely) x		
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	2 (Minor)		
Last Reviewed	01 July 2024	Risk rating	= 8 (Moderate)	= 4 (Low)		
Next Review Due (Bi-annually based on current risk score)	01 October 2024					

Key Controls <i>(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>(Are further controls possible to reduce risk exposure within tolerable range?)</i>	Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance/ Actions to Address Gaps <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Assurance Rating <i>(Overall Assessment)</i>
- Corporate Engagement Team - Patient Experience and Involvement Strategy- organisational ownership - Person Centred Care (PCC) Surveys via CIVICA - PCC KPI's (support PCC Quality pillar) 'You said..... we did' public facing information for service areas. - PLO service at GUH - Introduction of PALS Service (Oct 23) - Volunteer Patient Experience Feedback - Collaboration to recruit community listeners to support Dementia Awareness - Digital patient stories to support listening and learning. - Patient Experience and Involvement Strategy - DATIX - Oversight of Medical Examiner reports to determine patient experience actions - Public Engagement- Big Conversation Bereavement held 20th March 2024 - People Participation Panel ED in Progress	- Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress. - PCCT staff training to support Civica data entry and retrieval. - Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners. - Employment of dedicated PALS team who will have a key role in gaining feedback from patients, staff, and relatives. Monthly reporting in place and quarterly updates to QPSOG - Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data. No SMS provision. - Discussions with VBHC to pilot SMS in ED through DrDoctor - National directives around new national surveys that need to be managed additional to internal roll out programme. - Volunteer feedback to be reviewed to identify themes.	Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i> - Patient Experience and Involvement Team oversee patient experience through dedicated work programme and link in with divisional teams. - Concerns are fed back to divisional teams when identified. - Outcome of the volunteer feedback to drive improvements. - Patient Experience and Involvement Team undertaking Culturally Competent Accreditation - Immediate feedback and escalation to clinical teams following PALS queries and concerns	Gaps in Assurance - No SMS provision to increase the number of PCC surveys. - No single point of contact or 'drop in' provision for patients/families/staff to raise initial patient experience concerns. - Need to develop bereavement model and improve bereavement offer to meet Bereavement Standards. Resources being scoped. - Survey of bereaved people needs to be developed and rolled out to meet Bereavement Standards.	Reasonable Assurance
		Level 2 Organisational <i>(Executed by risk management and compliance functions)</i> - Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO) - Listening and Learning reported through QPSOG/ Outcomes Committee - Implemented PALS DATIX Module	Action to Address Gaps in Assurance - Discussions with VBHC team to consider SMS through DrDoctor with pilot at ED - PALS Single point of contact is established. PALS officers have key role in patient experience and involvement- including establishing 'drop in' clinics on hospital sites should patients/staff/relatives wish to discuss concerns. Ned to have discussions with facilities around rooms. - Patient experience KPI's and common themes need to be identified and reported through the PCC Survey. These will be added to a template patient experience report and CIVICA surveys will be built into ward accreditation.	
		Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i> - LLais Reports - HIW inspections - Advocacy reports		

RISK THEME		COMPLIANCE & SAFETY																																																																																
Risk No: SRR 010		There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974			Publication Status	Public																																																																												
Strategic Threat	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.			Risk Appetite Level - MINIMAL. Any risk that has a MINIMAL risk appetite level should be managed to a Score of 8 or below .																																																																														
				Risk Appetite Threshold - Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible / low likelihood of occurrence of the risk after application of controls.																																																																														
Impact	➤ Unintended physical harm; ➤ Punitive actions from the Health and Safety Executive (HSE); ➤ Increased levels of staff sickness; ➤ Loss of estate due to unsafe environments; ➤ Financial implications; ➤ Adverse publicity; and, ➤ Reputational damage			SUMMARY The current risk level is OUTSIDE of target level and OUTSIDE appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.																																																																														
				Strategic Risk SRR 010 <table><tr><th>Month</th><th>Current Risk Score</th><th>Target Risk Score</th><th>Appetite Threshold</th></tr><tr><td>Jun-23</td><td></td><td>6</td><td>8</td></tr><tr><td>Jul-23</td><td></td><td>6</td><td>8</td></tr><tr><td>Aug-23</td><td></td><td>6</td><td>8</td></tr><tr><td>Sep-23</td><td></td><td>6</td><td>8</td></tr><tr><td>Oct-23</td><td></td><td>6</td><td>8</td></tr><tr><td>Nov-23</td><td></td><td>6</td><td>8</td></tr><tr><td>Dec-23</td><td>16</td><td>6</td><td>8</td></tr><tr><td>Jan-24</td><td>16</td><td>6</td><td>8</td></tr><tr><td>Feb-24</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Mar-24</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Apr-24</td><td>12</td><td>6</td><td>8</td></tr><tr><td>May-24</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Jun-24</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Jul-24</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Aug-24</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Sep-24</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Oct-24</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Nov-24</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Dec-24</td><td>12</td><td>6</td><td>8</td></tr></table>			Month	Current Risk Score	Target Risk Score	Appetite Threshold	Jun-23		6	8	Jul-23		6	8	Aug-23		6	8	Sep-23		6	8	Oct-23		6	8	Nov-23		6	8	Dec-23	16	6	8	Jan-24	16	6	8	Feb-24	12	6	8	Mar-24	12	6	8	Apr-24	12	6	8	May-24	12	6	8	Jun-24	12	6	8	Jul-24	12	6	8	Aug-24	12	6	8	Sep-24	12	6	8	Oct-24	12	6	8	Nov-24	12	6	8
Month	Current Risk Score	Target Risk Score	Appetite Threshold																																																																															
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Lead Director	Director of Therapies & Health Science	Risk Exposure	Current Level	Target Level																																																																														
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	Likelihood	3 (Possible) X	2 (Unlikely) X																																																																														
Initial Date of Assessment	01 December 2023	Impact	4 (Major)	3 (Moderate)																																																																														
Date Reviewed	01 August 2024	Overall Risk Rating	= 12 (High)	= 6 (Moderate)																																																																														
Date of Next Review (Quarterly based on current risk score)	01 November 2024																																																																																	

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

• Implementation of Health, Safety, and Fire Improvement Plan for 2023/24 to address 7 risk areas of concern. • Health and Safety Governance and reporting arrangements (Health and Safety Committee)		• Performance reviews at All Wales Health and Safety Management Steering Group • Internal Audit – H&S processes Review to be included in 2024/25 Plan. • South Wales Fire & Rescue Service fire safety audit programme. • Health and Safety Executive reviews/inspections.	demonstrate progress against the Improvement Plan	

Internal Audit Progress Report

Audit, Risk and Assurance Committee

September 2024

Aneurin Bevan University Health Board

NWSSP Audit and Assurance Services

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2. Progress against 2024/25 Internal Audit Plan

3. Summary of Findings

4. Merger of Overlapping Audit Work

5. Other Activity

6. Recommendation

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Appendix B: Audit Assurance Ratings

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1. Introduction

The purpose of this report is to:

- confirm the status of the audit work for the 2024/25 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board') to the September 2024 Audit, Risk and Assurance Committee (the 'Committee');
- request approval for the merger of two audits, IMTP – Service Delivery Plans and Analytics Information Use, due to the opportunity of overlapping the proposed testing; and
- provide an overview of other activity undertaken since the previous meeting.

2. Progress against 2024/25 Internal Audit Plan

There are 30 individual reviews in the 2024/25 Internal Audit Plan, including assurance work completed by our Specialist Services Unit (SSU) over major capital projects.

The table below details progress against the 2024/25 Internal Audit Plan.

Number of audits in plan:	30
Less potential audit merger	(1)
Revised total	29
Number of audits at draft report stage	1
Number of audits work in progress	5
Number of audits at planning stage	9
Number of audits not started	14

In addition, the remaining 2023/24 final reports have been issued since the meeting of the Audit, Risk and Assurance Committee on 9th July 2024:

AUDIT ASSIGNMENT	ASSURANCE RATING
Savings Programmes	Reasonable
Waiting List Management	Reasonable

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

3. Summary of Findings

Limited assurance reports are considered by the Audit, Risk and Assurance Committee in detail. The following summary provides the Committee with the main messages from the reports issued since the last meeting on 9th July 2024.

Savings Programmes (reasonable assurance)

The audit tested the Health Board's savings programmes to ensure they are specific, realistic and measurable and that monitoring arrangements are effective. The audit did not assess the overall 2023/24 deficit position, but rather focussed on the delivery and management of savings programmes.

We confirmed that the Health Board evaluates savings achieved through a variety of mechanisms, linked to spending activity across the year. The 2023/24 savings target was £51.5m (2022/23 £17m), including a total of £30m of stretch targets. Additionally, £24.5m of further savings opportunities were identified in year. At the time of the audit, £43.5m was expected to be achieved across these cohorts combined.

Whilst the savings target was not fully achieved this year, considerable progress had been made. We also recognised that the savings target and the proportion achieved was higher than at any point within recent years. Alongside this, we also considered that early within the 2024/25 financial year, the Health Board adapted and strengthened the savings approach to target additional value, including assigned executives to lead on savings programmes, further efficiency savings identified and the operation of the Value and Sustainability Board.

However, we identified two matters arising relating to the use of a RAG rating indicator in the savings achieved/ forecast reports where the definition is absent. For example, a green RAG rated programme represents that savings have been made and are expected to continue, as opposed to an in-year achievement of the full savings amount. We also raised a recommendation over examining the savings target shortfall during 2023/24, to determine if savings plans can be extended further and / or if there are factors to incorporate into future planning arrangements.

Waiting List Management (reasonable assurance)

We reviewed the arrangements in place for establishing whether all patients on the waiting list have been assessed and assigned an appropriate priority rating and that suitable arrangements are in place to communicate and support those patients, where applicable.

Overall, waiting lists are reviewed, validated and managed, but this is significantly impacted by the size of the lists for certain sub specialties. Where controls are not automated, there remains an inherent risk of manual errors; however, the validation teams continuously review files to confirm patients are on the correct pathway. Given the size of some waiting lists, not all patients are continuously validated, but we found that the frequency was regular.

However, there is a significant challenge over the clinical reassessment and reprioritisation of a patient that is waiting for treatment. We raised several recommendations over the management of this risk, but ultimately patients are not re-assessed in line with the Welsh Government's requirement of continuously validating a patient's clinical priority.

4. Merger of Overlapping Audit Work

The Analytics and Information Use (AIU) audit assessed the use of data analytics by staff and whether it is utilised in a secure manner. Towards the end of the fieldwork phase and whilst planning the IMTP – Service Delivery Plans audit, we identified an opportunity to expand upon the initial testing within the AIU audit, to incorporate both sets of objectives into one review.

Consequently, the planned overlap of work would enable the merger of the two audits into one report covering both audits. To achieve this, we propose and seek **approval** for the merger of these two audits, by including an additional audit objective within the AIU audit.

The additional objective would specifically focus on the remaining modelling risks associated with the IMTP service delivery plans and would be presented separately within the final audit report.

5. Other Activity

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

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

6. Recommendation

The Audit, Risk and Assurance Committee is invited to **note** the above points within the report and to **approve** the merger of the two audits referenced within section four.

Appendix A: Progress against 2024/25 Internal Audit Plan

Audits	Status
Financial Sustainability	Not started
IMTP – Service Delivery Plans	Proposed merger
Contract Management	Planning
Facilities Stock	Work in progress
Performance Framework	Not started
Embedding of Policies	Not started
Declarations of Interest	Planning
Divisional Governance Arrangements	Not started
Directorate Review - Mental Health and Learning Disabilities	Planning
Maternity Services Improvement Plan	Not started
End of Life Care	Work in progress
Health and Safety (comprising of two parts)	Planning
Waiting List Management	Not started
Partnership Arrangements	Planning
Medical Equipment and Devices	Not started
Records Management	Planning
Job Planning	Planning
Staff Culture	Planning
Medical E-Rostering	Planning
Follow-up of High Priority Recommendations	Not started
Welsh Intensive Care System	Not started
Analytics and Information Use	Draft report (proposed merger)
Technical Continuity	Not started
Electronic document and records management solution	Not started
Capital Systems/Major Project Provisions (not separately provided)	Not started
Nevill Hall RAAC	Work in progress
Estates Assurance – Energy Management	Work in progress
Newport HWBC	Not started
NHH Regional Satellite Centre	Not started
The Grange A&E Expansion	Work in progress

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.

Savings Programmes Internal Audit Report August 2024

Aneurin Bevan University Health Board



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



Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board



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Review reference:	AB-2324-1
Report status:	Final
Fieldwork commencement:	30 th May 2024
Fieldwork completion:	21 st June 2024
Draft report issued:	27 th June 2024
Debrief meeting:	24 th June 2024
Management response received:	2 nd August 2024
Final report issued:	6 th August 2024
Auditors:	Stephen Chaney, Acting Head of Internal Audit Chris Scott, Internal Audit Manager
Executive sign-off:	Rob Holcombe, Director of Finance and Procurement
Distribution:	Suzanne Jones, Assistant Finance Director - Financial Strategy & Planning Greg Bowen, Assistant Finance Director Chris Cummings, Assistant Finance Director
Committee:	Audit, Risk and Assurance Committee



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

Acknowledgement

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

Disclaimer notice - please note

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

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

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

Executive Summary

Purpose

The overall objective of the audit is to provide assurance that the Health Board’s savings programmes are specific, realistic and measurable and that monitoring arrangements are effective. This audit did not assess the overall 2023/24 deficit position, including additional cost pressures / funding allocation received, but rather focussed on the delivery and management of savings programmes.

Overview

We noted the Health Board evaluates savings achieved through a variety of mechanisms, linked to spending activity across the year. The 2023/24 savings target was £51.5m (2022/23 £17m), including a total of £30m of stretch targets. Additionally, £24.5m of further savings opportunities were identified in year. At the time of the audit, £43.5m was expected to be achieved across these cohorts combined. We have considered this overall position when providing our assurance opinion, recognising that progress is still underway to achieve a sustainable position. Whilst the savings target was not fully achieved this year, considerable progress has been made. We also recognised that the savings target and the proportion achieved was higher than at any point within recent years. Alongside this, we also considered that early within the 2024/25 financial year, the Health Board adapted and strengthened the savings approach to target additional value, including assigned executives to lead on savings programmes, further efficiency savings identified and the operation of the Value and Sustainability Board.

We identified two matters arising relating to the use of a RAG rating indicator in the savings achieved/ forecast reports where the definition is absent. For example, a green RAG rated programme represents that savings have been made and are expected to continue, as opposed to an in-year achievement of the full savings amount. We also raised a recommendation over examining the savings target shortfall during 2023/24, to determine if savings plans can be extended further and / or if there are factors to incorporate into future planning arrangements.

Matters arising are included in more detail within Appendix A.

Report Classification

Reasonable	Some matters require management attention in control design or compliance.	Trend
	Low to moderate impact on residual exposure risk until resolved.	No recent comparative report available

Assurance summary¹

Assurance objectives	Assurance
1 Savings Plan	Substantial
2 Savings implemented and monitored	Reasonable

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

Matters arising		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Savings plan delivery RAG rating	2	Design	Low
2	Savings plans not achieved	2	Design	Medium

1. Introduction

- 1.1 The review of Savings Programmes was completed in line with Aneurin Bevan University Health Board's (the 'Health Board') 2023/2024 Internal Audit Plan.
- 1.2 Public sector organisations are under increasing pressure to ensure that their expenditure falls within the level of funding available within year, whilst meeting all of their operational goals and fulfilling statutory duties.
- 1.3 Recognising this, the Health Board put in place a savings programme to enable the organisation to work towards financial balance, whilst ensuring a sustainable service delivery.
- 1.4 The review focussed on the achievement of a sample of these planned savings.
- 1.5 The risks considered in this review included:
 - the Health Board does not achieve its savings target; and
 - the Health Board breaches its statutory duty to break even.

2. Detailed Findings

Objective 1: the Health Board has a savings plan in place

- 2.1 We sought to establish the mechanisms adopted by the Health Board to identify and estimate savings opportunities within their annual Financial Plan.
- 2.2 In order to evaluate the process end-to-end, we examined the 2023/24 completed planning and delivery cycle.
- 2.3 Budget setting for 2023/24 included the following steps for the identification of savings:
 - a generic savings target (£6.3m) of 0.75% for executive areas of delegation and 0.5% for other areas, excluding some ringfenced budgets;
 - specific savings plans (£17.9m) – where there is reasonable assurance that savings can be made in these areas with a reasonable plan to achieve it;
 - 'focussed opportunities' (£7.9m) where there is an indication that savings could be made but further work is required; and
 - stretch targets (£19.4m) which is the balance required to meet the agreed savings target. This includes areas of slippage on allocations and some suggested areas for focus.

Each of the divisions/ directorates were then assessed and allocated savings expectations accordingly.

2.4 Through this process savings targets were allocated to Divisions/ Directorates as follows:

Delegated Area £000's	Sum of Total CIP	Sum of Total Savings Plans	Sum of Total Focussed Opportunities	Sum of Total Stretch Savings	Sum of Total Savings
ABCI	(4)	0	0	(0)	(5)
Capital charges	0	0	0	0	0
Chief Executive and non officer members	(408)	0	(300)	(1,201)	(1,908)
Clinical Support Services	(290)	(277)	0	(26)	(593)
Community CHC & FNC	(320)	(305)	(200)	(1,057)	(1,883)
Director of Corporate Governance	(8)	0	0	(0)	(9)
Director of Operations	(76)	0	0	(3)	(79)
Director of Primary Community and Mental Health	(2)	0	0	(0)	(2)
Estates and Facilities	(496)	(892)	(170)	(4,281)	(5,838)
External Contracts	0	0	0	(2,000)	(2,001)
Family & Therapies	(641)	(1,298)	0	(137)	(2,076)
Finance & Procurement	(58)	0	0	(1)	(58)
Litigation	(11)	0	0	(2)	(12)
Medical Director	(28)	0	0	(0)	(28)
Medicine	(686)	(3,736)	(1,066)	(4,199)	(9,688)
Mental Health	(587)	(562)	(3,528)	(692)	(5,369)
Nurse Director	(39)	0	0	(2)	(41)
Planning & Digital/ICT	(181)	0	0	(116)	(296)
Prescribing	(560)	(60)	(1,000)	(768)	(2,389)
Primary Care & Community Services	(557)	(3,255)	(100)	(78)	(3,990)
Public Health Director	(36)	0	(1,000)	(3,001)	(4,037)
Scheduled Care	(1,001)	(7,297)	0	(335)	(8,633)
Shared Services	(0)	0	0	(0)	(0)
Specialist Services	0	0	0	(1,500)	(1,500)
Therapies Director	(8)	(47)	0	(0)	(55)
Urgent Care	(215)	(195)	(500)	(9)	(919)
Workforce & OD	(85)	0	0	(7)	(91)
Grand Total	(6,297)	(17,924)	(7,864)	(19,414)	(51,500)

Table 1: 2023/24 savings targets for divisions/ directorates

- 2.5 Savings targets were then included within delegated budget letters to the Executive Directors and through this process, these were adopted by the divisions and directorates accordingly.
- 2.6 Divisions and directorates identify, compile and submit individual savings schemes that in aggregate must meet the targets they have been set.
- 2.7 Individual savings schemes are then listed and incorporated into the Health Board's Financial Plan. Estimates for each are carried through the year and it is against these that monthly monitoring takes place (examined further under objective 2 below).
- 2.8 New schemes that are identified or emerge as the year progresses are added into the monitoring list.
- 2.9 Savings impact the Health Board's ledger codes as they are achieved, either as underspends at account level and/ or reductions made to the spend forecasts in future months.

2.10 We examined the savings scheme listings of four sample divisions as follows and noted that the aggregate of scheme values in each case agreed or reconciled to the target values in table 1 above:

- Medicine, £9.688m;
- Mental Health & Learning Development, £5.369m;
- Primary Care & Community, £4.170m; and
- Family & Therapies, £2.074m.

2.11 Savings plans of these divisions combined represent 45% (in value) of the Health Board's total planned savings for 2023/24 and sample testing of individual schemes from this cohort is documented under objective 2 below.

Conclusion:

2.12 We have not recorded any matters arising under this objective and therefore have provided **substantial assurance** over this area.

Objective 2: agreed savings plans are implemented, monitored and reported.

2.13 We sought to establish the means by which savings schemes are monitored for delivery through the examination of a small sample of savings schemes.

2.14 Savings schemes that have been agreed with divisions and directorates are listed, coded and recorded in a tracker spreadsheet.

2.15 The divisional finance teams, in conjunction with the divisions, identify the amount of savings that have been achieved each month.

2.16 Achievement risk of planned savings is indicated for each scheme using a simple RAG rating. We were advised that the definition applied to each of the RAG ratings in 2023/24 was that a saving scheme was to be shown as 'green' if an actual cash saving had been achieved and was forecasted to continue. It was not an indicator of full delivery of the savings target, although we note that there is no definition detailing this within the reporting materials (**see Matter Arising 1**).

2.17 Month on month and year to date savings achieved and forecast are recorded in the tracker and reported to the Board and sub-committees within the monthly Finance Report, and to the Welsh Government in the Monthly Monitoring Return (MMR).

2.18 We conducted a sample test of savings schemes status at month 10 of 2023/24, to review the methods by which actual savings achieved figures are being derived.

2.19 We noted that the approach adopted to evaluating and reporting achieved savings of the individual listed savings schemes is varied.

2.20 Sources of savings values encountered in the testing (see below) included payroll data, accounting records and service/ ward cessation plans.

2.21 We reconciled in detail one of our sample selected (Mental Health and LD) back to the general ledger and we did not identify any issues with this. We found that the achieved savings and summary results of the sample of 10 tested to be:

- six were taken from payroll data;

- two were taken from database accounting records (CHC database of patients receiving high value care packages);
- one was based on the savings in a ward closure plan that had been actioned; and
- one related to the receipt of additional funding for the expansion of a service.

2.22 The month 12 savings tracker records the full year aggregate savings in 2023/24 of £42.985m from the combined (i) full year saving plan value of £51.502m and (ii) £25.5m of savings opportunities identified in-year. The £43m of savings across these cohorts combined were reported by the Health Board as achieved in 2023/24. However, c.£8.5m was not achieved and there is a benefit to reviewing the individual schemes, to determine if more savings value can be obtained and / or if improvements to similar schemes can be incorporated in the future. Overall, there is need for a determination over whether the savings total can be increased further (**see Matter Arising 2**).

Conclusion:

2.23 We have raised two matters arising under this objective relating to savings plan RAG rating interpretation and a review over savings targets not achieved. Furthermore, we recognise that in most instances, within our sample selected, savings should continue to be generated in future years. Therefore, we have provided **reasonable assurance** over this area.

Appendix A: Management Action Plan

Matter arising 1: Savings Plan Delivery RAG Rating (Design)		Impact
We noted the application of RAG ratings in the savings achieved and forecast tables of committee and Board reports, do not provide a definition of the ratings reporting. We were advised that the definition applied by the Health Board to RAG ratings in 2023/24 was that a saving scheme was to be shown as 'green', if an actual cash saving had been achieved and was forecast to continue. It was not an indicator of full delivery of the savings target. We note that neither this definition, nor those of amber and red indicators, are recorded in the reporting materials and consider there to be a risk that readers of these may not fully understand the meaning of the indicator and from that, over-assess the likelihood of the scheme's planned savings being achieved.		Potential risk that RAG ratings on savings achieved reports are not fully understood.
Recommendations		Priority
1.1 We recommend that the RAG rating model used within the reports to the Board and sub-committees: clearly define the RAG ratings to avoid misinterpretation of the savings achievement likelihood.		Low
Management Responses	Target Date	Responsible Officer
1.1 RAG ratings used by ABUHB for financial reporting are aligned with the Welsh Government definitions and are consistent with Welsh Government MMR reporting requirements: Action - The definition will be included in the monthly finance report for clarity. Director of Finance – implemented for month 3 Board report July 24.	Implemented	Director of Finance

Matter arising 2: Savings not Achieved (Design)

Impact

The Health Board utilises multiple savings initiatives including cost reduction through to efficiency improvements. During the year, the Health Board achieved c. £43.5m of planned savings against a target of £51.5m and £25.5m of savings opportunities identified in-year combined. Whilst some savings programmes will have maximised their potential and others will be superseded / subsumed within new programmes of work, there is a benefit to considering if there are improvements to include for future programmes of savings. In essence, to determine if a different approach could be taken to further increase the total savings value.

In addition, there should be a consideration over whether individual savings programmes are monitored from one year to the next, to maximise delivery of savings.

Potential risk that the maximum level of savings is not achieved.

Recommendations

Priority

2.1 We recommend that the Health Board review the savings target shortfall and determine if improvements can be made to maximise the level of savings achieved. In addition, consideration should be given to tracking savings programmes into the next financial year.

Medium

Management Responses

Target Date

Responsible Officer

2.1 Savings delivery and opportunities to maximise delivery is the subject of monthly budget holder review and the V&SB process. The annual plan / IMTP process requires all potential opportunities to be considered and identified, including past schemes delivery levels and review of previous potential schemes not progressed. This is integral to the financial management and savings approach for ABUHB, including the in-year work of the V&SB. Several of the 'opportunities' requiring a QIA assessment as part of the 24/25 annual plan are related to revisiting previously discounted proposals. Where schemes were delivered on a part year basis in a prior year the underlying financial positions include the full year effect where recurrent as part of developing the new year financial plan.

Action – include 'explicit' action as part of 25/26 annual plan to confirm previous schemes have been reconsidered, as part of financial planning process.

December 2024

AFD – Financial Planning

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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Waiting List Management Final Internal Audit Report August 2024

Aneurin Bevan University Health Board



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Review reference:	AB-2324-12
Report status:	Final
Fieldwork commencement:	3 rd August 2023
Fieldwork completion:	29 th July 2024
Debrief meeting:	16 th August 2024
Draft report issued:	5 th August 2024 & 16 th August 2024
Management response received:	20 th August 2024
Final report issued:	28 th August 2024
Auditors:	Stephen Chaney, Head of Internal Audit Krisztina Kozlovsky, Internal Audit Manager Laura Howells, Principal Internal Auditor
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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 Chartered Institute of Public Finance & Accountancy in April 2023

Acknowledgement

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

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit, Risk and Assurance Committee. Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Aneurin Bevan University Health Board (the Health Board) and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

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

Executive Summary

Purpose

To establish whether all patients on the waiting list have been assessed and assigned an appropriate priority rating in line with the Royal College of Surgeons guidance and that suitable arrangements are in place to communicate and support those patients, where applicable, at Aneurin Bevan University Health Board (the 'Health Board').

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- reprioritisation or clinical reassessment of patients;
- continual patient validation; and
- communication with patients.

Overall, waiting lists are reviewed, validated and managed, but this is significantly impacted by the size of the lists for certain sub specialties. Where controls are not automated, there remains an inherent risk of manual errors; however, the validation teams continuously review files to confirm patients are on the correct pathway. Given the size of some waiting lists, not all patients are continuously validated, but we found that the frequency was regular.

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

Report Opinion

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

Assurance summary¹

Objectives		Assurance
1	Waiting lists	Reasonable
2	Actions plans and related monitoring	Reasonable
3	Patients' prioritisation	Limited
4	Communication with patients	Reasonable

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

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	Waiting list management	1,3 & 4	Design	High

Introduction

- 1.1 In line with the 2023/24 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board'), a review of waiting list management was undertaken. The objective of the audit was to establish whether all patients on the waiting list have been assessed and assigned an appropriate priority rating in line with the Royal College of Surgeons guidance, to include the arrangements in place to communicate and support patients.
- 1.2 Due to the pandemic and other related factors, there has been a sharp rise in referral rates, due to deteriorated health and patients requiring more complex and having higher acuity needs. This has increased the level of demand upon services, and adversely impacted the length of time patients are required to wait for their outpatient appointments and / or treatments.
- 1.3 There are Welsh Government initiatives (including formal targets) and Ministerial priorities that are required to be adopted and reported on. These are nationally set, and as such, all health boards must ensure that they have appropriate systems in place to capture the information necessary to meet and report on these requirements.
- 1.4 The key risks considered in this review were as follows:
 - waiting lists are not up-to-date;
 - patient harm due to excessive waiting times and / or appropriate care not offered in a timely manner;
 - lack of action to reduce the number of patients waiting for health care services;
 - insufficient monitoring / inaccurate record keeping; and
 - lack of adequate communication and support provided to patients.
- 1.5 We did not evaluate or review any evidence relating to patients' experience as part of this review. Furthermore, the audit reviewed the governance for waiting list management given the current climate and financial situation facing the Health Board, but excludes commenting on the actual size of the waiting list. The assurance rating, therefore, is based on our review over the steps taken by the Health Board to manage the waiting lists, against a backdrop of resource challenges.

Detailed Audit Findings

Objective 1: A waiting list is up-to-date and maintained, including links and connections between different lists

- 2.1 The Health Board maintains waiting lists that are grouped into three main categories:
 - diagnostic & therapy services;
 - referral to treatment times services; and
 - additional services.

- 2.2 Whilst efforts have been made to reduce the number of patients on the different waiting lists, the waiting times remain high. Waiting lists are regularly reported to Welsh Government (WG). This includes data of the RTT and diagnostic and therapy services.
- 2.3 We selected three waiting lists for detailed review across the three main categories:

Ref.	Specialist area	Service type
1	Trauma orthopaedic	RTT service
2	Diagnostic Endoscopy	Diagnostic and therapy service
3	Adult Weight Management	Additional service (non-RTT)

- 2.4 We also reviewed the key characteristics of these waiting lists e.g. their limitations and challenges, explored opportunities, and forecast details (see information regarding this summarised in Appendix C).

Waiting list links and connections

- 2.5 Waiting list data is held on the Welsh Patient Administration System (WPAS). WPAS is the main data source that is currently used for monitoring and reporting purposes (both external and internal reporting). However, there are a few exceptions from this:
- diagnostic and therapies data are taken from the Radiology System (RADIS) and Audiology System (Audit Base) – the nature of this data is event specific; and
 - mental health data is stored in the Welsh Community Care Information System (WCCIS).

Data quality checks

- 2.6 Quality checks are primarily undertaken through the validation exercise. Before information on waiting lists are submitted to Welsh Government, the data is reviewed, and quality checked. Any data issues identified at this stage would be handed back to the relevant directorate for investigation.
- 2.7 We confirmed that patients are being verified whilst on the waiting list. Staff within the Verification Team leave notes on the patient file and ensure the patient is still on the most efficient pathway.
- 2.8 The Health Board should be validating patients on the waiting lists continuously as set out in the Welsh Government document: ‘Our Programme for Transforming and Modernising Planned Care and Reducing waiting lists in Wales’ (‘Transforming Programme’). We noted for the Trauma and Orthopaedics directorate that given the size of the waiting lists, not all patients were continuously validated. There was evidence that the Health Board is utilising the workforce it has to validate patients daily, starting with those who have been on the waiting list for the longest period; but there is not enough resource to continuously review every patient file. Therefore, there is a risk some patients may not be on the best pathway or have up to date details. **Matter arising one.**

Conclusion:

- 2.9 Waiting lists are managed across the Health Board, however, there is an inherent risk of mistakes arising, due to the lack of automation of controls in operation. Whilst referenced against this objective, the matter arising raised links to objective 3. Therefore, we have provided **reasonable assurance** over this audit objective.

Objective 2: Effective action plans and related monitoring to reduce the size of current waiting lists, including any associated reporting.**Welsh Government Initiatives**

- 2.10 The care system was already facing challenges before the pandemic and required significant changes to meet current and growing patient demand. Therefore, the Welsh Government introduced the Transforming Programme during April 2022.
- 2.11 The Transforming Programme sets out a blueprint to address the sustainable recovery of planned care services across Wales. It aims for transforming and modernising planned care and reducing waiting lists. The Transforming Programme consists of five ambitions on how to reduce waiting times in Wales.
- 2.12 The Welsh Government also set national targets for certain specialty services (e.g. to offer appointments / provide treatment to patients within set weeks following their referral). The Health Board reported within the Finance and Performance Committee in March 2024 that progress is being made in reducing the number of the longest waiting patients for planned care treatments and outpatient appointments. However, with the rate of referrals and the current focus on treat in turn, there is a risk of greater waiting list growth.

Ministerial Priorities

- 2.13 The Ministerial Priorities were set for 2023/24 to support a swift recovery of business as usual, and to halt, then turn the tide, of growing waiting lists and waiting times. The desire to 'go further, faster' is embedded within partnership engagement activities associated with the 'Place Based Care' and 'Return and Stay Well at Home' (goals 5 & 6 Urgent and Emergency Care), supporting the development of the 'Complex Care Closer to Home' and 'Home from Hospital' national models of care. (See further information on these priorities in Appendix B).

Integrated Medium Term Plan (IMTP)

- 2.14 We reviewed the 2023/26 IMTP for the Health Board and found that it is expected that referral rates are going to be further increased by 3.7%, in addition to higher acuity needs.
- 2.15 The Health Board has completed an exercise to determine the potential demand, risks, and capacity requirements of the current waiting lists. This has been done by working with each clinical team, using real time data, realistic workforce assumptions, emerging experience of how patients are returning to services and

known system constraints. Consequently, the Health Board has sought to understand:

- the baseline position;
- predicted demand on the system (this includes known backlog, and a clinical assessment of unreferred needs in our communities);
- the capacity required, in comparison to what is available;
- how much has changed and what is the new 'normal';
- activity profiles in context of known constraints;
- potential impacts on the population's health; and
- a realistic 'most likely' scenario.

Initiatives

- 2.16 It was reported within the Finance and Performance Committee minutes that the 'spines' specialty has a lower backpain pathway in development between MSK therapy and orthopaedic services. We were informed by the Directorate Manager that this pathway will be in place by September 2024, but the impact of the pathway will be slowly realised and requiring behaviour changes from primary care. From our discussion with the Trauma and Orthopaedic Directorate Manager, we were informed this new pathway aims to reduce patients being added to the waiting list by 50%. At the time of the audit we were unable to verify this point.
- 2.17 Patients are encouraged to become involved in their care decisions when there are potential treatment options and administrative arrangements offered. All appointments within an RTT period must be arranged under the rules relating to reasonable offer, and therefore be mutually agreed between the patient and the Health Board. Based on the current practice, the reasonable offer currently includes two dates from which the patients can choose from.

Regional Working Projects (RWPs)

- 2.18 We found that there are limited links / communication amongst the health boards to collectively try to reduce the size of the different waiting lists in Wales. We note that initiatives had been launched by the Welsh Government to set up Regional Working Projects (RWP) and once of the projects most advanced related to Ophthalmology. The Health Board currently collaborates through the South East Wales Orthopaedic Programme Board and the South Wales Spinal Network. **Matter arising one.**

Conclusion:

- 2.19 We identified one high priority recommendation regarding monitoring and effective plans for the waiting lists, but this has primarily been reflected within objective three. Therefore, we have provided **reasonable assurance** over this audit objective.

Objective 3: Effective arrangements for prioritising patients based on their current health care needs (e.g. regular assessments and reprioritisation).

2.20 As mentioned under objective two, many of the different directorates operate their waiting lists differently. From our sample testing we found that the following approaches were in place:

Ref.	Specialist area	Reassessment of patients
1	Trauma orthopaedic	Patients are pre-assessed prior to logging them into the waiting lists, but they are not subject to any reassessments unless a formal second referral is received from the GP.
2	Diagnostic Endoscopy	Patients are pre-assessed prior to logging them into the waiting lists, but they are not subject to any reassessments unless a formal second referral is received from the GP.
3	Adult Weight Management	Patients are usually self-referring themselves into this service. There is triage at the beginning of the process to evaluate patients' conditions prior to being put on the waiting list. This is carried out based on information provided by the patient on the self-referral form. We note that prior to the Pandemic, this was based on an hour F:F interview with the patient. Reassessment on patients is not carried out routinely. However, if a triggering event happens (e.g. an additional referral is received from a GP or other sources), the patients' situation could be re-evaluated, and if it is needed, the process could be fast tracked, but this would be still subject to some waiting time.

2.21 Patients are risk scored into two categories, routine and urgent. Patients are not necessarily subject to regular reassessments. Reassessments usually only take place if a triggering event occurs e.g. an additional referral received or an expedite letter from the patient's GP. Additionally, the Directorate Manager informed us that there has been a significant rise in expedite requests which is driving referral activity and increasing the risk of duplicates on the waiting list. Expedites are partly driven by the increased waiting times due to the increased size of the waiting lists.
Matter arising one.

2.22 Referrals are subject to a clinical assessment prior to adding the patient to any waiting list. We also note that a summary of priority waiting times is currently reported to Finance and Performance Committee.

Conclusion:

2.23 We identified one high priority recommendation regarding patients' prioritisation (see matter arising one in Appendix A). Therefore, we have provided **limited assurance** over this audit objective.

Objective 4: Adequate arrangements to communicate with patients waiting for health care services, including the offer of additional support if required.**Template letters**

2.24 Template letters are in place to communicate with patients while they are assigned to a waiting list. These documents are usually available bilingually and automatically sent from WPAS. We reviewed the following outpatients template letters in detail:

- assurance letter - letter to all new outpatients without booked dates at 26 weeks – to establish if they still require their appointment;
- validation letter - letter to all new outpatients at 36 weeks to keep in touch; and
- validation letter – letter to outpatients at 52 weeks to keep in touch.

2.25 We noted that the validation letters sent to patients do not ask the patient if symptoms have changed or if they wished to proceed through another pathway e.g. physiotherapy. The letter simply confirms patient details. An opportunity is missed to reprioritise patients when these letters are returned without asking for this information and reducing waiting lists by not offering other pathways. **Matter arising one.**

Dr Doctor

2.26 The Health Board had introduced an appointment management and text reminder service to patients called Dr Doctor. However, we were informed that at the time of the audit, this service is no longer available. Without adequate replacement there is a risk that the Health Board is not utilising all available opportunities stay in touch with its patients. **Matter arising two.**

Conclusion:

2.27 We identified one high matter arising primarily associated with objective three and one low priority recommendation regarding communication with patients on waiting lists. Therefore, we have provided **reasonable assurance** over this audit objective.

Appendix A: Management Action Plan

Matter Arising 1: Waiting List Management (Design)	Impact
The Health Board should continuously validate a patient’s clinical priority, as set out in the Welsh Government document: ‘Our Programme for Transforming and Modernising Planned Care and Reducing waiting lists in Wales’ (‘Transforming Programme’). Patients are risk scored into two categories, ‘routine’ and ‘urgent’, but are not subject to regular reassessments. Reassessments usually only take place if a triggering event happened e.g. an additional referral is received or an expedite letter from the patient’s GP. We noted for the Trauma and Orthopaedics directorate that given the size of the waiting lists, not all patients were continuously validated. There was evidence that the Health Board is utilising the workforce it has to validate patients daily, starting with those who have been on the waiting list for the longest period; but we were informed that there is insufficient resource to review every patient file. Therefore, there is a risk some patients may not be on the best pathway or have up to date details. Furthermore, we found that there are limited links across NHS Wales organisations to collectively reduce the size of the different waiting lists in Wales. However, we note that initiatives have been launched by the Welsh Government, in particular to set up Regional Working Projects (RWP).	Potential risk of: • subjective decision making, as the waiting list may not fully reflect the current clinical status of patients; • missed opportunities to improve waiting times; and • patient harm.

Recommendations		Priority
1.1a	Management should review the process of managing waiting lists. A targeted approach to continual validation of patients ensuring they are on the correct pathways and are not duplicates should be undertaken.	High
1.1b	Consultants/clinical leads responsible for patients on waiting lists should periodically confirm their patients remain in the most efficiently prioritised order. Whilst recognising that significant resource and other constraints impact the Health Board’s aim to reduce the waiting lists, a review of whether overtime, further utilisation of theatres, collaboration with other Health Boards etc. should be completed to determine if there are feasible steps to take to reduce waiting times.	
1.1c	When reaching out to patients on the waiting lists, with letters confirming the patient details etc. are correct, options of different care pathways could be offered or options for reassessment considered if the patient’s condition has changed.	

Agreed Management Action		Target Date	Responsible Officer
1.1a	The Planned Care Academy purpose is to ensure that education and training of staff becomes embedded into ways of working, to develop and support staff as well as improving the effectiveness and compliance with national requirements relating to management of patients on their pathways. The development of tools, bespoke training packages, policies and standard operating procedures has now been completed. Initial training will provide basic RTT knowledge targeted at new starters and staff whose dealings with patient pathways are minimal. This cohort must still understand the concept of the 26 week pathway and the consequences of failing to record information correctly and in real time. Advanced RTT training is aimed at staff who require a full understanding of the 26 Week Rules. A comprehensive range of WPAS modules have been developed mirroring the patient pathway and designed to be role based i.e. tailored training. The training will include DNA's, how to rebook, the rules around Non-Admitted, Admitted and Incompletes, how to validate a PTL and what to look for within the data of a PTL to help manage pathways. Staff will learn how to record patient pathways correctly using the appropriate National RTT Status codes on WPAS. Refresher training will be provided to existing staff and competency assessed.	September 2024	Head of Health Records/Referral & Booking Centres

1.1b	The T&O directorate recognise the importance of scheduling both in and outpatient lists to ensure an appropriate balance between clinical priority and treating in turn. To support this, the Health Board planning team provide weekly detailed analysis of treat in turn data for RTT inpatient lists which has supported an improvement in treat in turn, which since May has increased from 65% to 80%, including listing out of turn reasons. Inpatient schedulers work very close with consultants to review theatre lists. Clinical time to review waiting lists is not currently achievable whilst available clinical sessions are prioritised for delivering direct patient care. The gains available to the directorate from treat in turn, validation and other improvement programmes such as theatre efficiency, are incremental in terms of the gains they deliver in comparison with the size of the challenge. As highlighted in recent reviews, the directorate was previously heavily reliant on additional activity to support the RTT position. The difficult decisions taken by the Health Board to support the financial challenges meant that additional activity is largely no longer supported at the same scale. As such, significant improvements in waiting times cannot be achieved without investment in both additional activity, to address the backlog, and long term sustainable service plans.	March 2025	Directorate Manager – T & O

1.1c	Our Outpatient Waiting List validation letter is currently a standard letter that is sent to all services. It is generated by DHCW (rather than directly on WPAS) who have limited resource and so we are not able to tailor letters to specific patients via this process currently. WPAS development is planned to enable us to run our own validation data sets and set up our own letters on WPAS which would allow us to be able to tailor letters by specialty/sub specialty. If we were to offer different care pathways we would need to be able to identify appropriate patients at clinical condition level, this would require resource at either a clinical or clerical validation level to identify appropriate patients. If patients do indicate on their current responses their condition has changed/worsened we send this to the relevant directorate teams. We do not directly ask for clinical information in our current process, if this was to be incorporated then resource and escalation routes would need to be identified in each directorate. Unfortunately, at this time we are not able to adapt the current process but can review this when the WPAS change takes place. If a need is identified for a particular cohort of patients then we will explore validating via 'mail merge' but this would be on a smaller scale than our current validation.	March 2025	Deputy Outpatient Transformation Lead

Matter Arising 2: Dr Doctor (Design)		Impact
At the start of the audit the Health Board had in place an appointment management and text reminder service to patients called Dr Doctor. However, we were informed that, this service is no longer provided.		Potential risk of: Health Board may miss opportunities to engage with patients
Recommendations		Priority
2.1	The Health Board should review whether there are other alternatives to Dr Doctor that could/should be embedded to improve communication to patients.	Low

Agreed Management Action		Target Date	Responsible Officer
2.1	DrDoctor has been replaced with Envoy which is a patient communication software, with outcomes in an instant with reporting designed by NHS users. Despite initial challenges, the software is in place with a phase 1 rollout plan as follows: • Implementation of a lockdown on letter templates. • Introduction of a Standard Operating Procedure (SOP) and a change control process for any requested alterations to SMS or letter templates • Rationalised letter templates. • Biweekly project meetings are now scheduled with RBC and podded services, which will also tie into outpatient transformation meetings. • The implementation of clinic locations and sub-specialties in SMS has begun, with services required to validate this information prior to activation. • The necessity for bi-directional SMS is currently under evaluation. • Process mapping has been completed in collaboration with RBC and podded services. • A WPAS product team is being developed to set standards for WPAS usage across the Health Board, alongside improved training initiatives.	March 2025	Deputy Chief Operating Officer

	Keeping Well Single Point of Contact The Keeping Well Single Point of Contact Team will be contacting patients on waiting lists and directing patients to appropriate resources etc, starting with the Treatment list in one specialty initially. This service has been created in accordance with Welsh Government direction and will begin phoning patients in September 2024.		

Appendix B: Data extracts from IMTP Ministerial Priorities

- Number of patients waiting for outpatient appointments and treatments

		Over 36 weeks for new outpatient appointment				Over 52 weeks for new outpatient appointment				Over 104 weeks for treatment*				Over 156 weeks for treatment			
Ref.	Specialty	06/2023	09/2023	12/2023	03/2024	06/2023	09/2023	12/2023	03/2024	06/2023	09/2023	12/2023	03/2024	06/2023	09/2023	12/2023	03/2024
1	ENT	5,308	5,430	5,576	5,839	3,349	3,411	3,332	3,407	265	234	220	185	91	66	-	-
2	General Surgery	519	445	491	538	-	-	-	-	52	-	-	-	-	-	-	-
3	Gynaecology	1,778	1,655	1,692	1,726	-	-	-	-	-	-	-	-	-	-	-	-
4	Maxillo-facial	1,080	1,236	1,464	1,631												
5	Ophthalmology	7,167	7,804	8,706	9,608	435	564	650	735	-	-	-	-	-	-	-	-
6	Orthopaedics	2,817	2,107	1,970	2,107	4,066	4,498	4,792	5,208	-	-	-	-	-	-	-	-
7	Urology	2,154	2,483	2,899	3,312	1,882	1,918	1,710	1,898	1,151	900	665	450	299	196	-	-
TOTAL		20,823	21,160	22,798	24,761	10,612	11,372	11,528	12,387	1,650	1,293	1,017	756	390	262	0	0

- Report Framework 23/24 – dashboard measures

Ref	Ministerial Priorities	Measure / Outcome	Baseline (March 23)	Planned vs Actual	Quarter 1	Quarter 2	Quarter 3	Quarter 4
1	Cancer Recovery	Reduction in backlog of cancer patients waiting over 62 days	343	Planned	<300	<250	<250	<250
				Actual	375			
		Percentage of patients starting definitive cancer treatment within 62 days from point of suspicion	56%	Planned	60%	65%	70%	>75%
				Actual	60.2% (May)			
2	Mental Health and CAMHS	Assessment by LPMHSS within 28 days from referral	78.3%	Planned	80%	80%	80%	80%
				Actual	Validated data available from July			
		Interventions <28 days following assessment by LPMHSS	18.1%	Planned	80%	80%	80%	80%
				Actual	Validated data available from July			
		CAMHS 4+ week waiting list	98.1%	Planned	80%	80%	80%	80%
				Actual	Validated data available from July			
3	Planned Care, Recovery, Diagnostics and Pathways of Care	Number of patients waiting more than 52 weeks for a new outpatient appointment	9,834	Planned	10,729	10,979	10,311	9,802
				Actual	11,362 (May)			
		Number of patients waiting more than 36 weeks for a new outpatient appointment	20,031	Planned	19,138	19,240	19,228	19,463
				Actual	21,659 (May)			
		Number of patients waiting more than 104 weeks for treatment	1,821	Planned	1,260	903	428	0
				Actual	1,635 (May)			
		Number of patients waiting more than 104 weeks for a new outpatient appointment	781	Planned	625	284	127	0
				Actual	1,313 (May)			
		Number of patients waiting more than 52 weeks for treatment	8,547	Planned	7,822	7,462	7,377	7,173
				Actual	7,470 (May)			
4	Primary care access to services	Units of Dental Activity (UDAs) delivered	410,048	Planned	92,777	185,554	278,331	371,108
				Actual	116,878			
		Number of patients accessed NHS Opthometry Services	139,860	Planned	35,496	70,992	106,488	141,984
				Actual	39,910			
5	Delayed transfer of care	Reduction in the number of Pathway of Care Delays	275	Planned	<249	<232	<217	<203
				Actual	241			
6	Urgent & Emergency Care	Number of ambulance patient handovers over 1 hour	1,497	Planned	1,066	1,347	1,471	1,521
				Actual	1,285			

Appendix C: Key characteristics of selected waiting lists

Ref.	Specialist area	Limitations / challenges	Explored opportunities
1	Trauma orthopaedic	• Significant capacity deficit in core capacity to meet demand; • Previous reliance on additional activity to meet demand which has ceased due to financial constraints • outsourcing model not a consideration in the directorate, nor funds available to support; • . • Staff deficit in some sub specialities to enable a sustainable service (orthopaedic consultants, and specialists such as hand physio therapists) • There is a limitation to adopt the use of virtual appointments; • Access to theatres are limited by backfill/ WLI cessation • Also efficiency of theatres varies by location. There is a mismatch on staff availabilities for the theatres in some locations (e.g. anaesthetic, consultant etc...); • Less focus on regional services, as bed deficit or theatre access is not an issues in health board • Use of "Artificial Intelligence" has been explored. • Waiting times are impacted by issues such as fitness, weigh tmanagment, diagnostic waits. • Non-compliance with Royal College Clinical prioritisation – because of current capacity challenges. • Breaches are not investigated because of the large volume of them.	• Workforce diversification – bringing in more clinical specialist, but not consultants. • Daily validation (2.5 FTE). • Currently piloting a self-management app called: "My recovery", supports orthopaedic patients only, rolling out to all hip and knee surgeons currently.

Ref.	Specialist area	Limitations / challenges	Explored opportunities
2	Weight Management / Dietitian services	- The landscape because of the Pandemic and other factors has changed. Lots of people are doing less exercise, many gained weight during lockdown. Increase in motivation to make changes to weight and an increased awareness of the public of implications of high body weight. Healthy Weight is a WG priority and so enhanced awareness for both public and health professionals. - Very small budget and no increase in budget with new medications added to the pathway. - New treatment options such as Saxenda medication has generated surge in demand as can only be prescribed via a Tier WMS. More medications coming and already adding more numbers. - Increased demand for bariatric surgery (Tier 4) to which Tier 3 is the gatekeeper. To access Tier 4 bariatric surgery patients must engage and be assessed for surgery prior to referral. - Staff vacancies especially in Tier 3 and lack of resource for new treatments at Tier 3 (e.g. drug can be only prescribed by a registered consultant and have 6 sessions/month for all pathways). - Spikes in the referrals after the Healthy Wales initiative where Slimming World was offered as an alternative at Tier 2. - Due to service re-design and running of new and old clinic codes, many patients may be incorrectly coded, and cancellations may raise because of this.	- In April 2023, Dr Doctor system was trialled for patients to cancel their appointments via text. - Adopted process from England of a new demand and capacity tool which is still in progress. - More information was provided to patients prior to their appointments and the service website is in the process of being restructured to provide additional resources. - Slimming World on referral was introduced as a pathway option for all patients accessing the service. - A more simplified self-referral form was launched online. Also, offered telephone help to patients to fill in the self-assessment form (including call back option). - One hour initial consultation (IC) was stopped on 31/10/22 and replaced with clinical triage of self-referral form. Only self-referral was accepted into the service at this point to enable the clinical triage to be carried out. - Workforce redesign, 'check ins' were delegated to be run at Band4 levels and rotational posts were introduced. Tier 2 services had been offered to Tier 3 patients who have been assessed pre-November 2022. - Formal monitoring was put in place to measure benefits and unintended consequences. - Increased virtual activity.

Ref.	Specialist area	Limitations / challenges	Explored opportunities
3	Diagnostic endoscopy - gastroenterology	- Number of equipment used for endoscopy purposes are limited. There would be a need for additional capital investment to improve this. - Financial constraints to utilise services from private companies. - Referrals are currently manually recorded to Welsh PAS system (WPAS), and EMS (Endoscopy Medi Logic) – this is labour-intensive double work (hopefully, will be automated using robotic help in the next month – discussions have already started to solve this issue). - No advance technology (e.g. AI) in place yet to analyse screening data. This area has not been explored yet. - Current booking process is based on average 12 points per day (points are applied to time slot times for diagnostic and treatment activities) – therefore there are limited opportunities to schedule overbookings.	- There is a contract in place with “Remedy Health Service” for insourcing activities within Endoscopy by the end of November 2023. This will be replaced with in-house theatre activities after it through a new unit opening in November 2023. - Backfill activities are on-going. - Currently training up three new registered endoscopy screeners. - Opportunities were considered to generate income and take on patients from other Health Boards through “spy glass”. Work took place to develop a formal contract with the Commissioning. - Screening services were launched to change the process and allow early diagnosis instead of relying on GP referrals only. - Automatic follow ups based on initial assessments.

Appendix D: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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



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Development of a Regional Radiotherapy Satellite Centre (RSC) at Nevill Hall Hospital Final Internal Audit Report

September 2024

Aneurin Bevan University Health Board

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Review reference:	ABU-SSU-2324-04
Report status:	Final
Fieldwork commencement:	9 th January 2024
Fieldwork completion:	12 th June 2024
Draft report issued:	13 th June 2024 & 18 th July 2024
Draft report meeting:	1 st July 2024
Management response received:	29 th August 2024
Final report issued:	2 nd September 2024
Auditors:	NWSSP Audit & Assurance – Specialist Services Unit
Executive sign-off:	Hannah Evans, Executive Director Strategy, Planning and Partnership
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Committee:	Audit, Risk & Assurance Committee



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

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

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

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are

prepared for the sole use of the Aneurin Bevan University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

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Executive Summary

Purpose

The audit was undertaken to review the delivery and management arrangements in place to progress the development of a Regional Radiotherapy Satellite Centre (RSC) at Nevill Hall Hospital, and the performance to date against its key delivery objectives i.e. time, cost, and quality. This was the second audit of the RSC project; the previous review having determined **Reasonable Assurance**.

Overall Audit Opinion and Overview

At the time of the current review, the project was at a mid-construction stage i.e. with approximately 12 months remaining of the extended 26-month contract period. The (10-week) extension to the contract period had primarily arisen due to adverse ground conditions being identified under the demolished ante-natal clinic.

In addition, Welsh Government had agreed to fund Reinforced Autoclaved Aerated Concrete (RAAC) remedial works totalling £334k plus VAT (RAAC) was found to be present in an area of the existing hospital which will link into the new unit.

At the time of the review, the Supply Chain Partner was reporting the forecast completion of the scheme approximately 3 weeks earlier than the extended contract completion date, with the Project Manager reporting delivery marginally outside of the FBC approved budget allocations. However, it was acknowledged that remaining quantified contingency sums were sufficient to address the current forecast overspend (in the event of all identified risks not materialising).

The audit found the following issues:

- The need to enhance the governance and scrutiny arrangements applied at both the Project Board, including the receipt and assessment of key project documents;
- The need to undertake a thorough assessment of the potential project risks

Report Classification



Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.



2023/24

Assurance Summary ¹

Assurance objectives	Assurance
1 Project Performance	Reasonable
2 Validation of Management Action	Reasonable
3 Project Governance	Reasonable
4 Financial Management	Reasonable
5 Validation of Costs	Reasonable
6 Site progress	Reasonable
7 Equipping	Substantial

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

through to completion and the adequacy of the remaining contingency funds;

- An assessment of the Project Bank account (PBA) arrangements applied at the project should be undertaken; and
- Full compliance with the UHB’s Scheme of Delegation in respect of invoice authorisation.

Accordingly, an overall **reasonable assurance** has been determined.

Further information and additional recommendations are provided within the detail of the report.

Key Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
1.1	Project Board meetings will be held at the required frequency.	3	Operation	Medium
3.1	Compliance with UHB’s Standing Orders/ Reservation and Delegation requirements at the payment of all supplier invoices.	5	Operation	Medium
4.1	Performance management information regarding the prompt rectification of snags, defects, etc., should be consistently provided	6	Design	Medium
5.1	Project Progress Returns (PPRs) should be shared with (and scrutinised by) the Project Board prior to their submission to Welsh Government.	4	Design	Medium
5.2	The PPRs should incorporate the latest versions of associated project reports and documents e.g. risk register.	4	Operation	Medium
6.1	A thorough reassessment of remaining project risks should be undertaken to update the risk register and confirm the remaining contingency requirements	1 & 4	Operation	Medium
6.2	The Project Board should demonstrate ongoing scrutiny and management of the project risks (and available contingency funds) through to completion.	1 & 4	Operation	Medium
6.3	The Project Board should be appraised of any discrepancies, inefficiencies, or risks associated with the project's cash flow.	1 & 4	Operation	Medium

Introduction

- 1.1 The audit reviewed the delivery and management arrangements in place to progress the development of a Regional Radiotherapy Satellite Centre (RSC) at Nevill Hall Hospital. This audit was commissioned in accordance with the agreed Audit Plan (and associated fee) provided within the approved Full Business Case (FBC) for the project.
- 1.2 The project aims to deliver the Regional Radiotherapy Satellite Centre to support the existing, and in due course new, Velindre Cancer Centre in its provision of Radiotherapy services for the population of Southeast Wales.
- 1.3 The potential risks considered in this review included:
 - The failure to achieve key project objectives through poor governance and project management controls.
 - Breach of Welsh Government (WG) funding requirements, Standing Orders or Standing Financial Instructions.
 - The target cost may not provide sufficient value for money.
 - Poor performance may not be identified and addressed.
 - Project costs may escalate uncontrollably through an absence of adequate cost monitoring and reporting.
- 1.4 The Welsh Government approved funding of £37.185m in respect of the Regional Radiotherapy Satellite Centre on the 16th of December 2022.

1. Detailed Audit Findings

Project Performance: Summary of the achievement of the project's key delivery objectives (time, cost and quality) to date.

- 2.1 At a project audit, levels of assurance were determined on whether the project achieves its original key delivery objectives and that governance, risk management and internal control within the area under review were suitably designed and applied effectively.
- 2.2 At this second audit of the development of a Regional Radiotherapy Satellite Centre (RSC) at Nevill Hall Hospital, when assessing progress against the original delivery objectives, the following was evidenced:

Time

2.3 The project time performance is summarised below:

	Business Case	Contract	Revised Contract	SCP current programme (M05.02)
Commencement	August 2022	12 th December 2022	12 th December 2022	12 th December 2022
Completion	February 2024	25 th November 2024	21st February 2025	30 th January 2025

- 2.4 The overall contract completion date was revised to the 21stFebruary 2025, following an agreed extension to the original programme of 88 days, as a result of implemented compensation events.
- 2.5 The delay was primarily attributed to adverse ground conditions identified under the now demolished Ante Natal Clinic. This resulted in a compensation event being awarded to the Supply Chain Partner (SCP) in the sum of £0.468m plus VAT.
- 2.6 Noting the above, at the time of the current review, the SCP’s latest programme forecast completion of the scheme approximately 3 weeks earlier than the extended contract completion date.

Cost

2.7 The forecast out-turn cost position, as summarised at the March 2024 Commercial Cost Report (No15), was:

Costs	FBC Approval (incl RAAC Funding) £	March 2024 £
Works	23,349,361	24,280,020
Fees	3,091,000	3,151,509
Non-Works Costs	2,324,500	2,423,300
Equipment	25,500	25,500
Quantified Risk Contingency	1,413,000	440,906
VAT	6,040,672	6,064,247
VAT Recovery (provisional)	(156,200)	(173,808)
Total	36,087,833	36,211,673

2.8 Accordingly, at the time of the current review, the project was forecast to be marginally outside of the FBC approved budget allocations (£123,840/0.3%). Noting the same, £440,906 of remaining contingency was reported as available through to contract completion i.e. enabling delivery within budget if remaining contingency risks do not materialise.

2.9 Whilst noting the £441k (31%) of the quantified risk contingency available with 12 months (46%) of the 26-month extended contract period remaining, it may be considered that the construction risks and the associated contingency requirements through to completion appear reasonable. However, the costed project risks remained relatively high at £522k i.e. exceeding the remaining contingency balance by £81k (Note: It was indicated at the draft report discussion that the risk/available contingency position had further deteriorated i.e. £850K remaining risks against a reduced contingency of £366k). Project risks and contingency funds will therefore need to be carefully monitored and controlled throughout the remainder of the works. **MA6.2**

Quality

- 2.10 The original investment objectives (included within the business case) were to:
- To build new hospital infrastructure that supports quality and safe services.
 - To provide sufficient capacity to meet future demand for services.
 - To improve patient, carer and staff experience.
 - To provide capacity and facilities to support the delivery of high-quality education, research, technology and innovation.
- 2.11 Key Performance Indicators (KPIs) were completed in October 2023 in respect of the SCP, the UHB’s Advisers and the appointed Supervisor, with no material issues raised relating to the quality of service received.
- 2.12 Whilst recognising the current stage of the project delivery programme, the project was forecast to be delivered within the approved cost envelope (subject to identified risks not materialising) and earlier than the extended contract completion date. Therefore, **reasonable assurance** had been determined in respect of project performance.

The following sections of the report further outline the key observations that had contributed to the above – matters which require management attention, with moderate impact on residual risk exposure until resolved.

Validation of Management Action: *to confirm that previously agreed recommendations had been appropriately actioned by management.*

Original Priority Rating	Number of Recommendations	Implemented	Not implemented	Closed / superseded
High	1	1		
Medium	6	4	1	1
Low	2	2		
Total	9	7	1	1

2.13 Recommendations requiring further action are detailed at **Appendix B**. The key outstanding/ superseded recommendations related to:

- Previously recommended that the UHB should seek to obtain the necessary collateral warranties at the earliest opportunity. The UHB have since advised that this will be addressed by February 2025. Whilst noting that, completing collateral warranties before work begins is regarded as best practice because it establishes a solid legal foundation, safeguards the interests of all parties, helps prevent disputes, ensures compliance with financial and legal requirements, and contributes to the smooth execution of the project. This proactive approach mitigates risks and enhances the likelihood of project success.

2.14 Recognising the actions taken, **reasonable assurance** had been determined in relation to actions take to address previously agreed actions.

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

2.15 A revised version of the Project Execution Plan (PEP) (v.14) was published in October 2023. It was evident that this had been revisited at key milestones during the Project lifecycle.

2.16 The key project roles of Senior Responsible Officer (ABUHB Director of Planning and Partnerships) and Project Director (Strategic Capital and Estates Programme Director) had been appropriately assigned, with clear visibility at the Project Board and Project Team respectively.

2.17 The Project Board and Project Team's responsibilities were well defined, with appropriately constituted membership to deliver the same.

2.18 Terms of Reference (ToR) were in place for both the Project Board and Project Team.

2.19 The ToR for the Project Board called for monthly meetings, however for the period reviewed it was noted that they had been held bi-monthly, jointly with Velindre University NHS Trust (VUNHST)(**MA1.1**)

2.20 Whilst noting some improvements to governance processes were required for the current stage of the project, these were not sufficiently material to adversely impact the opinion and **reasonable assurance** had been determined in this area.

Financial Management/ Monitoring: To obtain assurance that adequate cost control and reporting systems were operated, both internally and by the External Cost Adviser.

- 2.21 Progress Reports were included as a standard agenda item at Project Board meetings, incorporating time, quality, and cost updates. The minutes of the meetings demonstrated some discussion informed by the progress reports.
- 2.22 The latest cost report dated March 2024 noted that the Project was 56% complete, with 31% of the initial risk contingency budget remaining. With 44% of the project still remaining, project risks and contingency funds should be reviewed, carefully monitored and controlled throughout the remainder of the works. **(MA6.1), (MA6.2)**
- 2.23 There had been a reported reduction in the projects cashflow for 2023/24. At the end of month 10 the actual costs incurred were running £1.5m behind the planned cashflow. **(MA6.3)**
- 2.24 A risk register was maintained by the external Project Manager; and monitored and reported to the UHB as part of the Project Board agenda. This risk register had been scored and costed accordingly.
- 2.25 It was noted however that the risk register included within the January 2024 Project Progress Return (PPR) to WG was dated July 2023 and therefore was not the most up to date version. **(MA5.2)**
- 2.26 The PPR returns to WG included all the expected reports and updates with the exception noted, however the PPR did not appear to have been shared with the Project Board to confirm its content prior to submission. **(MA5.1)**
- 2.27 Noting the issues raised in respect of overall project performance, **reasonable assurance** had been determined in respect of the financial management and monitoring arrangements applied at the project to date.

Validation of Costs: Adequate processes and procedures were in place to ensure that the contractor and advisers were correctly reimbursed in accordance with the contract.

- 2.28 A Project Bank account (PBA) had been established with the first payments made utilising this occurring in January 2024. This was however several months into the construction stage.
- 2.29 There was a total of eight PBA eligible work packages which had been awarded to seven different suppliers, of these however six suppliers had chosen not to take up the offer of a PBA.
- 2.30 This information is recorded within a tracker document maintained by the UHB's Cost Advisers.
- 2.31 As part of the review, copies of PBA opt out forms were sought and provided by the Cost Adviser. Five of the expected six opt-out forms were provided. It was

noted that an email from the supplier concerned had been included providing a suitable degree of assurance.

- 2.32 It was noted that two packages of work with a combined value in excess of £600k were latterly excluded from the PBA process (resulting from the split of the works packages), with the PBA Tracker noting they were not applicable.
- 2.33 What was not clear was whether the suppliers were originally approached about the PBA and this offer was then rescinded, or indeed if they along with other suppliers were made aware of their option to be considered even when falling below the threshold **(MA2.1)**.
- 2.34 The Late Payment of Commercial Debts (Interest) Act 1998, as amended by the Late Payment of Commercial Debts Regulations 2002 requires public bodies to pay within 30 days or potentially be liable for interest i.e. 8% above bank of England base rate (pro-rata). A sample of 3 months invoices submitted in respect of the UHB's advisers were assessed for appropriate approval and timeliness of payment, all had been appropriately authorised for payment and all had been paid in keeping with the Public Sector Payment Policy and the terms as detailed on the supplier invoices.
- 2.35 The Supply Chain Partner (SCP) payment time frames fall under the terms and conditions of the NEC form of contract applied at the project. A sample of 3 months invoices issued by the SCP were reviewed. All were appropriately assessed, certified and processed for payment, in accordance with the contractual payment terms.
- 2.36 Noting the same, at one of invoices, no audit trail confirming appropriate authorisation for payment in accordance with the UHB's Scheme of Reservation and Delegation (SORD) was evidenced. **(MA3.1)**
- 2.37 Noting the initiation of the PBA and appropriate and timely reimbursement of suppliers and advisers, **reasonable assurance** was therefore determined in relation to validation of costs.

Site progress: To obtain assurance that appropriate internal and contractual change control mechanisms were applied at the project; and that adequate site safety for both the Contractor, UHB and other staff was maintained on site through to project completion; the supervisor role was adequately delivered.

- 2.38 The change management process (Compensation Event / Early Warning Notice) was detailed within the National Engineering Contract 3 (NEC3) adopted.
- 2.39 The PEP was updated in September 2023 (v.13) to include a revised internal governance change control process. The PEP also included the Health Board's Capital Project Change Management Procedure as an appendix (v.14 2nd October 2023).

- 2.40 The Project Manager's monthly report distributed to Project Board and Project Team members included a copy of the Project's change control register. In accordance with the UHB's Capital Project Change Management Procedure this included Change Requests, Compensation Events and detail on the resolution of each.
- 2.41 The Supervisor team had access to site records (drawings, programme etc.) via A-Site (a construction document management system).
- 2.42 The Supervisor provided weekly progress & activity reports. Regular site visits were evident, accompanied by the generation of monthly reports submitted to the Project Board. However, these reports omitted details re: the quantity of snags, defects, or observations essential for the SCP to address. Consequently, the ability to proactively oversee the SCP's performance in rectifying issues was restricted.
(MA4.1)
- 2.43 A 'Health, Safety & Environment' section was included within the SCP's monthly Contractor's Report. This report was provided to both the Project Board and Project Team.
- 2.44 Health & Safety visits undertaken were noted, including the SCP's Safety Adviser monthly inspection/visits along with the less frequent SLT visits.
- 2.45 The Safety, Health & Environment (SHE) Site Inspection Visits Reports undertaken by the SCP Safety Adviser were considered comprehensive.
- 2.46 Noting the above, **reasonable assurance** had been determined in respect of site progress.

Equipping: to ensure that the equipping process was aligned with the key construction delivery timetable, and that there were appropriate management and reporting arrangements in place to ensure its coordination.

- 2.47 The level of approved WG funding for the Project was £48,597,000. This included VUNHST funding for equipment which was being managed directly under the IRS Programme totalling £11,412,000 and risk money associated with 'Exceptional Market Volatility' totalling £1,356,000.
- 2.48 Velindre University NHS Trust (VUNHST) is responsible for the procurement of major equipment for this project via its Integrated Radiotherapy Solution (IRS). The IRS Programme is subject to separate audit exercises reporting to the VUNHST.
- 2.49 ABUHB controlled equipment budget represented only £25k out of a budget of £35.8m.
- 2.50 The joint Project Board and Project Teams provided oversight and governance for the delivery of the build and Linac Bunker, to ensure essential engagement with

key stakeholders critical to the success of the overall scheme - membership included key project leads from the VUNHST IRS programme.

- 2.51 The agenda and minutes of the joint Project Meetings reviewed as part of this audit demonstrated good cross-organisational dialogue with VUNHST contributing Highlight reports generated from their own workstreams.
- 2.52 Noting the joint working and timely communication between the UHB and VUNHST above, **substantial assurance** had been determined in respect of equipping.

Appendix A: Management Action Plan

Matter Arising 1: Project Board – meeting frequency		Impact	
The Project Board provides a key role within the project governance structure providing oversight, scrutiny, guidance, and decision-making authority, ensuring that the project is aligned with the UHB’s objectives and successfully delivered. The Project Board’s Terms of Reference required monthly meetings. However, during the period reviewed meetings were held bi-monthly i.e. reducing the level of scrutiny and oversight afforded to the project. The Project Director indicated that as this was a joint board meeting with VUNHST, it had proved difficult from a resource availability and co-ordination perspective, to hold the meetings monthly.		Potential risk of: Insufficient oversight and scrutiny of project performance by the Project Board and Health Board Executive.	
Recommendations		Priority	
1.1	Project Board meetings will be held at the required frequency (monthly) providing appropriate project scrutiny and oversight. Alternatively revised arrangements may be considered appropriate e.g. alternating UHB and Joint Board (with VUNHST) provisions.	Medium	
Agreed Management Action		Target Date	Responsible Officer
1.1	The Project Board now regularly meets on a Monthly basis as per the Terms of Reference. The role of SRO and Chair of the Project Board is now jointly undertaken by the Executive Director for Planning, Strategy and Partnerships for AB and the Interim Chief Executive for VCC.	Actioned	Project Director

Matter Arising 2: Project Bank Account – Take up issues		Impact
The purpose of a PBA is to safeguard sub-contractors who may be exposed to cash flow risk, WPPN 03/21 notes that <i>the Use of PBAs aligns with the WPPS 2021 vision for Procurement in Wales as a lever with ability to affect sustained change to achieve social, economic, environmental and cultural outcomes for the well-being of Wales” and Principle 5 to, ‘...support Welsh Government policy objectives relating to progressive procurement...which nurtures resilient local supply chains.’</i> To this end the WPPN specifies that even those contractors whose award value falls below the 1% of total main contract award value may be paid through a PBA if required/requested. It was noted that for this project, two packages of work with a combined value in excess of £600k were latterly excluded from the PBA process (resulting from the split of the works packages), with the PBA Tracker noting they were not applicable. It was not clear whether the suppliers were originally approached about the PBA, provided with the option to utilise the PBA or offer refused/rescinded etc.		Potential risk of: Not meeting the spirit of WPPN03/21 as a “lever with the ability to affect sustained change to achieve social, economic, environmental and cultural outcomes for the well-being of Wales”.
Recommendations		Priority
2.1	The UHB should seek to better understand the low level of PBA take up in respect of this scheme and how those contractors below the award value threshold were engaged.	Low
Agreed Management Action		Responsible Officer
		Target Date

2.1	Further clarity has been sought as to why some companies opt-out of PBA's. It has now been agreed that the Opt-Out Form will state why the subcontractor declined to participate in the PBA. This will also be applied to any future projects and if deemed appropriate, further conversations will be held.	Actioned	Project Director

Matter Arising 3: Invoice approvals		Impact
The UHB's Scheme of Delegation notes that for all Wales capital projects: <i>the following process is to be applied where payments exceeding £100K are delegated to the Director of Planning, Digital and IT for approval:</i> <i>The External Cost Advisor (Quantity Surveyor representing the Health Board) shall advise the Health Board that a stage payment to the Supply Chain Partner (SCP) can be made and of the amount.</i> <i>The Project Director will have authority to approve payments of less than £50K.</i> <i>The Director of Planning, Digital and IT will have delegated authority to approve any payments exceeding £50K</i> For the sample of three Supply Chain Partners invoices submitted covering the period October to December 2023, one invoice (9th October 2023 in the sum of £1.068m plus VAT) did not include an appropriate audit trail confirming appropriate authorisation for payment in accordance with the UHB's Scheme of Reservation and Delegation. It was however acknowledged that the invoice was raised against the contract purchase order number, and as such a mitigating control was in place.		Potential risk of: Lack of compliance with UHB Scheme of Delegation.
Recommendations		Priority
3.1	The UHB should ensure appropriate signed authorisation for every invoice submitted in accordance with the UHB's Standing Orders Reservation and Delegation.	Medium
Agreed Management Action		Responsible Officer
		Target Date

3.1	Agreed - Authorisations are always carried out in line with the scheme of delegation. Further authorisation measures have now been put in place to ensure a physical signature is provided on Authorisation Forms prior to the invoice payment. This will also be rolled out to all Capital Projects.	August 2024	Project Director

Matter Arising 4: Supervisor Role – Site Progress (Design)		Impact	
At the initiation of the project, the Health Board engaged an external contractor to serve as the supervisor (in accordance with the NEC contract requirements). Regular site visits occurred, accompanied by the generation of monthly reports submitted to the Project Board. However, these reports lacked the necessary detail regarding the quantity of snags, defects, or observations essential for the SCP to address. Consequently, the ability to proactively oversee the SCP's performance in rectifying issues was constrained.		Potential risk that: The Health Board may incur time prolongation and increased costs due to snagging not being timely rectified.	
Recommendations		Priority	
4.1	Performance management information regarding the prompt rectification of snags, defects, etc., should be consistently provided, highlighting trends (monthly). This reporting should include details on completed items, outstanding issues, and other relevant updates etc.	Medium	
Agreed Management Action		Target Date	Responsible Officer
4.1	Agreed - The Health Board has access to RDRIVE which is the site where all details of the Snags, defects, etc are uploaded by the Supervisor and updated by the Contractor once they have been completed. The Health Board receives a weekly report from this site so that it can track progress against issues raised. Additionally, the Kier Aftercare produce a tracker with all snags/defects for formal review by the Health Board. Monthly meetings will be undertaken to review and sign off.	February 2025	Project Director

Matter Arising 5: Project Progress Reports- Welsh Government (Operation)			Impact
There is a requirement to submit Project Progress Returns (PPRs) for Welsh Government capital funded projects on a bi-monthly basis for review / consideration at the All-Wales Capital Programme meetings. The regular submission of the PPRs is has been acknowledged for the Regional Radiotherapy Satellite Centre is acknowledged. However, evidence to support the submission and consideration of the PPR's to the Project Board (or an alternative appropriate internal forum) to enable appropriate scrutiny and challenge prior to its submission to Welsh Government was not identified. It is also essential that the latest versions of associated project reports and documents are included within the PPR submission. Noting the same, the January 2024 PPR included the July 2023 project risk register.			Potential risk of: - Reduced understanding / scrutiny of project performance. - The Project Team may not adequately be informed on project financial information.
Recommendations			Priority
5.1	Project Progress Returns should be shared with (and scrutinised by) the Project Board (or an alternative appropriate internal forum) prior to their submission to Welsh Government.	Medium	
5.2	Project Progress Returns should incorporate the latest versions of associated project reports and documents e.g. risk register.		
Agreed Management Action		Target Date	Responsible Officer
5.1	Agreed - Project Progress Returns are now reported to Project Board on a Bi Monthly basis.	Actioned	Programme Manager
5.2	Project Progress Returns now include the latest versions of project reports.	Actioned	Programme Manager

Matter Arising 6: Financial Monitoring/Reporting (Operation)	Impact
The NHS Wales Infrastructure Investment Guidance (2018) states: <i>"The importance of gaining accurate information on spend cannot be emphasised enough. It is essential that organisations ensure that the information from Supply Chain Partners is up to date and contains realistic forecasts in terms of completed works and valuations. Early warning of any issues needs to be identified to the Deputy Director of Capital, Estates & Facilities Division. Careful attention needs to be given to underspend at all times throughout the project timeline."</i> It was also noted that there had been a reduction in the projects cashflow for 2023/24. The PPR to WG January 2024 noted that: <i>"The 2023/24 CRL allocation was reduced in October by £0.975m in line with the contractor's October cash flow forecast. At the end of month 10 the actual costs incurred are running £1.5m behind the planned cashflow. This is in part due to lower than forecast spend on contingency and because the contractors current forecast of defined costs is currently £758k plus VAT below the agreed target cost."</i> However, the project cashflow as identified in the PPR return was not subject to dialog at Project Board Meetings where it would be anticipated there would be active engagement; seeking clarity on aspects of the financial reports that are unclear or raise concerns. Whilst acknowledging that the construction was approximately 14 months into the extended 26-month contract period i.e. 54% complete, approximately £441k (31%) of the original £1,413k project contingency remained. At the time of the current review, the costed project risks remained relatively high at £522k, exceeding the remaining contingency balance by £81k. It may be considered that the remaining construction risks and the associated contingency requirements through to completion appears reasonable but will require careful management and ongoing scrutiny by the Project Board through to completion. It was indicated at the draft report discussion that the risk/available contingency position had further deteriorated i.e. £850K remaining risks against a reduced contingency of £366k.	Potential risk of: • Reduced understanding / scrutiny of project performance.

Similarly, there was no recorded further analysis or additional information on the remaining project contingency requested by the Project Board.		
Recommendations		Priority
6.1	A thorough reassessment of remaining project risks should be undertaken to update the risk register and confirm the remaining contingency requirements.	Medium
6.2	The Project Board should demonstrate ongoing scrutiny and management of the project risks (and available contingency funds) through to completion.	
6.3	The Project Board should be appraised of any discrepancies, inefficiencies, or risks associated with the project's cash flow. This highlighting of key project financial metrics to the Project Board would allow for an informed understanding of the financial health of the project and any potential issues that need to be addressed and ensure appropriate challenge and scrutiny.	
Agreed Management Action		Target Date
6.1	Agreed – a Risk Register Review will be undertaken and will ensure that it is updated to reflect the remaining contingency requirements.	October 2024
6.2	Agreed -once reviewed this will be discussed and scrutinised at the relevant Project Board.	October 2024
		Responsible Officer
		Project Director
		Project Director

6.3	Agreed - Project Cash Flow to be discussed at Project Board, ensuring that any potential risks are highlighted.	September 2024	Head of Capital Finance

Appendix B: Status of previously agreed recommendations (2022/23)

Development of a Regional Radiotherapy Satellite Centre (RSC) (March 2023) Previously providing					
Ref	Area	Previously agreed Action	Current Status	Revised Responsibility & Timescale	Priority Rating
1.1	Governance -PEP	The Project Execution Plan should be updated to reflect current governance arrangements.	Implemented The Project Execution Plan had been revised regularly since the last review, with several iterations having been published to reflect changes including governance arrangements.	Closed	Low
2.1	Governance- Project Board/Team Terms Reference of	Terms of Reference will be enhanced to ensure adequate governance arrangements are applied	Implemented- revised Terms of Reference produced.	Closed	Low
2.2	Governance- Attendance at Project Board/Team meetings	Members of the respective Meeting groups should be reminded of the need to regularly attend meetings.	Implemented - Discussed at Project Board meeting held in June 2023, with SRO for the scheme reminding members of their responsibility.	Closed	Medium

Development of a Regional Radiotherapy Satellite Centre (RSC) (March 2023) Previously providing					
Ref	Area	Previously agreed Action	Current Status	Revised Responsibility & Timescale	Priority Rating
3.1	Financial Monitoring	Deeds should be signed as a priority and the Project Bank Account established in line with Wales Procurement Policy Note WPPN 04 which was supported by the requirements of the University Health Board's Standard Financial Instructions section 15.4.8.	Implemented – Project Bank Account established with first payment made in January 2024.	Closed	Medium
3.2	Financial Monitoring	Pending implementation of the Project Bank Account, the University Health Board should seek assurances from the Supply Chain Partner in respect of the timely payment of its subcontractors.	Superseded	Superseded	Medium
4.1	Target Cost	The Project Board will retrospectively scrutinise the tender report to affirm that value for money had been attained at the agreed Target Cost.	Implemented	Closed	High
5.1	Contractual Arrangements	The Project Manager's and Cost Adviser's Confirmation Notice No.1	Implemented	Closed	Medium

Development of a Regional Radiotherapy Satellite Centre (RSC) (March 2023) Previously providing					
Ref	Area	Previously agreed Action	Current Status	Revised Responsibility & Timescale	Priority Rating
		will be resubmitted for signature by the UHB Chair.			
6.1	Design Development	User sign-off of the design and derogations should be formally recorded	Implemented January 2024: Completed, Linac Bunker layouts had been signed off by the VT following a number of changes requested by them.	Closed	Medium
7.1	Design Development	The UHB should seek to obtain the necessary collateral warranties at the earliest opportunity	UHB commented as follows in the audit Tracker as maintained: November 2023: there are numerous collateral warranties that occur at numerous points in the contract therefore this would not be completed until the end of the contract, i.e. February 2025. At this point in time the process for the provision of collateral warranties had not required to be	Project Director February 2025	Medium

Development of a Regional Radiotherapy Satellite Centre (RSC) (March 2023) Previously providing					
Ref	Area	Previously agreed Action	Current Status	Revised Responsibility & Timescale	Priority Rating
			actioned as the relevant works had not been completed. Noting this, best practice guidance would involve the completion of collateral warranties before work begins. The ongoing absence of this increases risks and could potentially affect the likelihood of project success		



Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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



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

Date issued: September 2024

Document reference: 3997A2024

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

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About this document

- 1 This document provides the Audit, Risk and Assurance Committee with an update on our current and planned accounts and performance audit work at Aneurin Bevan University Health Board.
- 2 We also provide additional information on:
 - Other relevant examinations and studies published by the Audit General.
 - Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.
- 3 Details of future and past Good Practice Exchange (GPX) events are available on our [website](#).

Accounts audit update

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

Exhibit 1 – Accounts audit work

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

Performance audit update

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

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment – Deep dive on financial efficiencies	Chief Executive Officer	In addition to the core structured assessment work, we will also undertake “deeper dive” work in a specific area. We had initially identified digital transformation as the deeper dive topic for 2023. However, given the financial challenges facing the NHS at present, we are looking to now focus our deep dive work in health boards on financial savings / cost improvement plans.	Report being drafted	November 2024

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Review of Unscheduled Care	Chief Operating Officer	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. The work will include an examination of the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow (Part 1). We also plan to review progress being made in managing unscheduled care demand by helping patients access services which are most appropriate for their unscheduled care needs (Part 2).	Part 1 – Regional report in internal clearance Part 2 – Report being drafted	November 2024

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment 2024 - Core	Chief Executive Officer	Our structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2024 Structured Assessment will review: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning and management arrangements.	Fieldwork underway	November 2024
Quality Governance Review Follow up (Local Work)	Executive Director of Nursing Medical Director Executive Director of Therapies and Health Sciences	The work will assess the extent to which previous audit recommendations arising from our thematic review of Quality Governance arrangements have been implemented and are delivering the intended outcomes / benefits. It will also focus on the Health Board's preparedness for the Duty of Quality and Candour and the effectiveness of its governance arrangements in providing assurance over its compliance.	Fieldwork in progress	January 2025

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
All-Wales thematic review of planned care	Chief Operating Officer	This work will follow on from the national <u>report on tackling the planned care backlog</u>. Whilst the exact focus of this work is still to be determined, it is likely to consider: • The extent that health boards have achieved Welsh Government targets for recovering planned care services; • The efficacy of local plans and activity to recover waiting lists; and • Use of the additional Welsh Government financial allocations to improve waiting lists.	Fieldwork in progress	January 2025
Structured Assessment 2024 Deep Dive - Review of investment in digital systems	Chief Executive Officer	This review will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.	Scoping	To be confirmed

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Eye Care Review (Local Work)	Chief Operating Officer	The precise focus of this work is still to be determined but will look to assess the Health Board's eye care services to ensure they are delivered efficiently, effectively, and economically, and there are clear plans to meet current and future population needs.	Scoping	To be confirmed

Other relevant publications

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

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

Title	Publication Date
<u>Community Pharmacy Data Matching Pilot</u>	May 2024
<u>Governance of National Park Authorities</u>	April 2024
<u>Supporting Ukrainians in Wales</u>	March 2024
<u>From firefighting to future-proofing – the challenge for Welsh public services</u>	February 2024

Additional information

7 **Exhibit 4** provides information on corporate documents published by Audit Wales since the last committee update. Links to the documents on our website are provided. There are no relevant Audit Wales consultations currently underway.

Exhibit 4 – Audit Wales corporate documents

Title	Publication Date
<u>Annual Report and Accounts 2023/24</u>	August 2024



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Rydym yn croesawu gohebiaeth a
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Audit Committee Chairs Operating Arrangements

1. INTRODUCTION

The chairs of the Audit Committee Group was established to provide an opportunity for Wales-wide discussions on emerging issues on: governance, risk management, financial controls, cyber security and counter fraud.

2. SCOPE AND DUTIES

The scope and duties of the group will comprise:

- Discussion of common issues arising from internal and external audit reviews.
- Discussion of the highest risks relating to governance, nationally and locally.
- Sharing cultural and thematic challenges and good practice and learning.

Items to be placed on the agenda will be informed by the group's action plan but can come from several sources such as those below but are not limited to:

- Group members.
- Board or trust committees.
- Chair, vice-chair and other members of the boards.
- Directors of Corporate Governance/board secretaries' network or other all-Wales peer groups.
- Audit Wales and Internal Audit.
- NHS Counter Fraud authority.

3. MEMBERSHIP

The membership will comprise chairs of Audit committees across Wales.

Should an NHS body Audit Committee Chair be unable to attend, a representative from the organisations will be identified by the body's Audit Chair.

4. MEETINGS

Hosting

The hosting organisation of the group will rotate every year.

Quorum

At least six members must be present to ensure the quorum.

Chair

The group will nominate a member to chair and this will rotate on a yearly basis.

Secretariat

The Director of Corporate Governance/Board Secretary of the hosting organisation will determine the secretarial and support arrangements for the group.

Frequency of Meetings

Meetings shall be held quarterly. Thematic working groups will be convened as and when required.

Committee Meetings

A standard agenda will be used as the basis for discussion at each meeting. Notes prepared following a meeting shall be circulated to members and retained by the relevant Director of Corporate Governance/Board Secretary as a formal record of the decision making for a period of seven years.

Withdrawal of individuals in attendance

The group may ask any member or individual who is normally in attendance but who is not a member to withdraw to facilitate open and frank discussion on any matter.

5. REVIEW

These operating arrangements shall be reviewed annually.

Last reviewed in July 2024



Trust Instructions for Completion

All scoresheets issued for completion.

When data has been collected, the Project Manager is to confirm this on the

- 2 Every 6 months (in March and September each year) report the following KPI data for all live projects:
 - Framework Performance (PM, CA, PD, SCP - light green tabs)
 - Project performance data tabs are completed incrementally from completion of stage 2: OBC development to stage 5: Construction completion. *N.B. Refer to the grey KPI Summary tab for details of when to complete and return each Project Performance KPI.*
- 3 As soon as the project is completed, ALL Project KPIs are to be reported, as well as the Framework Performance KPIs and the Employer Performance KPIs.
- 4 **Self-assessment and collaborative scoring is not permitted.**
- 5 Use the following 10 point scale to complete the Framework performance KPIs:
 - 10 Totally satisfied / Exceptional performance
 - 9 Very satisfied / Excellent performance
 - 8 Satisfied / Very good performance
 - 7 Mostly satisfied - Good performance
 - 6 Neutral - tending towards satisfied
 - 5 Neutral - tending towards dissatisfied
 - 4 Somewhat dissatisfied / several areas less than satisfactory
 - 3 Mostly dissatisfied - many areas less than satisfactory
 - 2 Very dissatisfied / Unacceptable performance in several areas
 - 1 Totally dissatisfied / Unacceptable performance in almost all areas
 - Not Applicable

Guidance on the 1-10 scale used for assessing the impact of defects is available by hovering the mouse over the defects data collection section of End of Project data form.
- 6 Email completed data forms to the designated Framework Manager for the project at NWSSP Specialist Estates Services who can be contacted in the event of any query.
- 7 Select the grey KPI summary tab for a list of all KPIs, their definitions and the parameters used for determining star-ratings

KPI Plan NHSBfW: (National Framework)

Performance parameter	Key Performance indicator	Definition	DfL BfW 3 Requirement	When to measure	Star rating parameters						Weighting for calculation of project star-rating
Framework Performance KPIs					Ú	ÚÚ	ÚÚÚ	ÚÚÚÚ	ÚÚÚÚÚ		
Framework performance	Quality of core services	Performance rating using 1-10 scale	Complete the 6-monthly survey	6 monthly (March and September)	Av <6	Av = 6-7	Av = 7=8	Av = 8-9	Av = 9-10		
	Timely delivery of services/information										
	s										
	Collaborative approach										
	Appropriate resourcing										
	Commitment to safety										
Overall performance (calculated average)											
Employer Performance KPIs											
Employer performance	Quality of service delivery	Performance rating using 1-10 scale	Complete the 6-monthly survey	6 monthly (March and September)	Av <6	Av = 6-7	Av = 7=8	Av = 8-9	Av = 9-10		
	Timely delivery of information and decisions										
	Clear aims and objectives										
	Commitment to project / appropriate resourcing of delivery team										
	Collaborative approach										
	Commitment to safety										
Overall performance (calculated average)											
Project KPIs											
Cost	Target Price Comparator	Project Allowance for construction (as defined)	Target Price to be 5% below Project Allowance Construction Cost as defined	Completion	>105%	105%-100.1%	100%- 95%	94.9%-94%	<94%	25 %	5 %
	Target Price Comparator	Final assessment of Price for Work Done to Date as % of final total of the	Final assessment of price for Work Done to Date to be less than or	Completion	>105%	105%-100.1%	100%-97.5%	97.4%-95%	<95%		5 %
	Total Project Spend	Amount of total project spend paid through a PBA	Target 80% of project spend (excluding ancillary charges	Completion	<70%	70 to 79.9%	80 %	80.1 to 90%	90.1 to 100%		5 %
	SCMs paid through a PBA	Supply chain members paid under a PBA expressed as a % of project spend	Target 90% for all T2 supply chain contractors	Completion	<80%	80 to 89.9%	90 %	90.1 to 95%	95.1 to 100%		5 %
	SCMs paid through a PBA	Supply chain members paid under a PBA expressed as a % of project spend	Target 80% for T3 supply chain contractors	Completion	<70%	70 to 79.9%	80 %	80.1 to 90%	90.1 to 100%		5 %
Time	Project time predictability	Actual project duration compared to contract programme	Project completed on time, allowing for agreed changes to completion date	Completion	>2.5%	0.1% - 2.5%	0% (on time)	-0.1% - -2.5%	< -2.5%	15 %	15 %
Quality	Quality of Design (AEDET)	AEDET Evolution toolkit scores	'Green' (4 or more out of 6) in all relevant categories	Prior to completion of stage 2: OBC and stage 3: FBC and no later than 3 months post handover	Av < 3.0	Av = 3.0 to 3.9	Av = 4.0 to 4.4	Av = 4.5 to 5.0	Av > 5.0	15 %	10,50 %
	Defects - impact	Performance rating using 1-10 scale	Target: 0 defects (10/10)	Completion	<7	7	8	9	10		3,25 %
	Defects - number at handover	Number of defects recorded on the inspection record appended to the completion certificate	Zero	Completion	>100	51-100	26-50	1-25	0		1,25 %
Safety	Safety	RIDDOR reportable accidents AFR	AFR to be 20% less than national average	6 monthly during stage 4: Design Completion & Construction (March and September)	AFR > 0.70	AFR = 0.70 - 0.59	AFR = 0.58 - 0.47	AFR = 0.46 - 0.01	AFR = 0 (Zero reportable accidents)	10 %	10 %
	BREEAM (New build projects)	BREEAM Assessment Model Rating (as built)	Excellent	Prior to completion of stage 3: FBC and no later than 3 months post handover	< 55.00	55.00 - 69.99	Excellent (= 70)	70.01 - 84.99	Outstanding (≥85)		14,00 %
	BREEAM (Refurbishment projects)	BREEAM Assessment Model Rating (as built)	V Good	Prior to completion of stage 3: FBC and no later than 3 months post handover	< 45.00	45.00 - 54.99	Very Good (=55)	55.01 - 64.99	≥ 65		
	Energy - CO2 - EPC	Energy Performance Asset Rating	Rating B (minimum 40)	Completion	EPR > 75	EPR = 41-75	EPR = 40	EPR = 39-26	EPR = 25-0		3,50 %
	Waste: re-used and recycled material content	Value of reused and recycled materials incorporated into the project as a percentage of total material value (assessed using the WRAP Net Waste tool)	Min 15% by value	Completion	<10%	10% - 14.9%	15 %	15.1% - 20%	>20%		1,75 %
	Waste generation	Waste generated during construction phase (tonnes per 100 m² gross internal floor area)	Waste generated not to exceed 13 tonnes / 100 m² of gross internal floor area	Completion	>16	16-13.1	13	12.9 - 10	<10		1,75 %

Sustainability	Waste recycling and recovery	% recycling / recovery of waste by weight	Excavation (non-hazardous): min 95%	Completion	<90%	90%-94.9%	95 %	95.1% - 99%	>99%	35 %	2 %
			Demolition: min 85%		<80%	80%-84.9%	85 %	85.1% - 90%	>90%		
			Construction: min 80%		<70%	70%-79.9%	80 %	80.1% - 90%	>90%		
			Refurbishment / strip out: min 70%		<60%	60%- 69.9%	70 %	70.1%-90%	>90%		
	Use of local labour	Percentage of employees that live within the following bands: 0 - 20 miles (but within Wales) 21-50 miles (but within Wales) 50+ miles (but within Wales) Outside Wales	Maximise % within Wales	6 monthly during stage 4: Design Completion & Construction (March and September)	<50%	50% - 59.9%	60% - 70%	70.1% - 80%	>80%		5,00 %
	Use of local suppliers/subcontractors	Percentage of value of supply and subcontracts let to Welsh companies	Maximise % within Wales	6 monthly during stage 4: Design Completion & Construction (March and September)	<50%	50% - 59.9%	60% - 70%	70.1% - 80%	>80%		7,00 %

Survey of SCP Performance



Assessor details		Project details:	
Partner role		LHB/Trust	
Co. name		Project no.	
Indiv. name		Project name	
Date		Project type	
		Project stage	
Score using the 1-10 scale.		Comments	Score
A: Quality of core services			
1	The SCP manages the design team efficiently to produce a fully integrated design.		-
2	The SCP understands the NEC contract and carries out their duties as Contractor under it.		-
3	The SCP ensures that risk management systems are in place and risk is managed proactively, regularly and effectively.		-
4	The SCP ensures that change management systems are in place, ensuring that change is identified early on and managed proactively and effectively.		-
5	The SCP leads and manages the construction		-
6	The SCP leads and manages the supply chain well.		-
7	The SCP produces documents to a high standard and holds the construction and design team to the same standards.		-
B: Timely delivery of services/information			
1	The SCP efficiently manages their own time.		-
2	The SCP efficiently manages time of the construction and design team members.		-
3	The SCP delivers their documents and information to		-
C: Commitment to key project objectives			
1	The SCP manages the programme proactively and has put systems and procedures into place to mitigate delay and ensure change request impact is managed.		-
2	The SCP ensures that appropriate cost control systems and reporting mechanisms are in place.		-
3	The SCP ensures that appropriate quality management systems and reporting mechanisms are in place for both design and construction activities.		-
4	The SCP ensures that appropriate risk management systems are in place, ensuring that risk is identified early on and managed proactively and effectively.		-
D: Collaborative approach			
1	The SCP has established clearly defined objectives for the construction and design team and supply chain.		-
2	The SCP has ensured all team members understand their roles and responsibilities and those of others.		-
3	The SCP has set down appropriate communication processes which are open and honest and facilitate		-
4	The SCP actively identifies and facilitates necessary design and construction team training.		-
5	The SCP champions collaborative and cooperative working throughout the team.		-
6	The SCP proactively engages with the client in setting up and operating the Project Bank Account.		-
7	The SCP ensures that the target for their supply chains to be paid through a PBA.		-
E: Appropriate resourcing			
1	The SCP has adequate time to spend on the project and invests the necessary time to discharge their duties.		-
2	The SCP has an adequate level of ability and experience to manage the project and project team effectively.		-
F: Commitment to safety			
1	The SCP demonstrates a competent awareness of health and safety legislation and ensures the CDM		-
2	The SCP promotes vigilant health and safety awareness within the design team.		-
3	The SCP promotes vigilant health and safety awareness within the construction team with clear		-
Performance summary		Comments	Score
A: Quality of core services			-
B: Timely delivery of services/information			-
C: Commitment to key project objectives			-
D: Collaborative approach			-
E: Appropriate resourcing			-
F: Commitment to safety			-
G: Overall Performance			-
SCP star rat		Comments:	

Survey of PM Performance



Assessor details		Project details:	
Partner role		LHB/Trust	
Co. name		Project no.	
Indiv. name		Project name	
Date		Project type	
		Project stage	
Score using the 1-10 scale.		Comments	Score
A: Quality of core services			
1	The PM has a good level of understanding of the		-
2	The PM has a good level of understanding of the business case process and manages the project		-
3	The PM understands the NEC contract and operates <i>it effectively.</i>		-
4	in place and risk is managed proactively, regularly and effectively.		-
5	The procurement and change management systems are in place and change is managed proactively and effectively.		-
6	The PM ensures that a stakeholder management plan is in place and stakeholder interests are managed effectively throughout the project.		-
7	The PM leads and manages the project team well.		-
8	The PM produces documents to a high standard and holds the project team to the same standards.		-
9	brief with clear critical success factors and key objectives.		-
10	The PM manages procurement and tendering processes effectively.		-
B: Timely delivery of services/information			
1	The PM efficiently manages their own time.		-
2	The PM efficiently manages time of other team		-
3	The PM delivers their documents and information		-
C: Commitment to key project objectives			
1	The PM manages the programme proactively and has put systems and procedures into place to mitigate delay and ensure change request impact is managed.		-
2	The PM ensures that appropriate cost control systems and reporting mechanisms are in place.		-
3	The PM ensures that appropriate quality management systems and reporting mechanisms are in place for both design and construction phases		-
4	The PM ensures that sustainability issues are a key consideration of the design process and are followed through during construction with clear monitoring		-
D: Collaborative approach			
1	The PM has established clearly defined objectives for the project team.		-
2	The PM has ensured all team members understand their and others roles and responsibilities.		-
3	The PM has set down appropriate communication processes which are open and honest and facilitate		-
4	The PM actively identifies and facilitates necessary project team training.		-
5	The PM champions collaborative and cooperative working throughout the team.		-
6	The PM proactively engages with the client in setting up and operating the Project Bank Account.		-
E: Appropriate resourcing			
1	The PM has adequate time to spend on the project and invests the necessary time to discharge their <i>duties.</i>		-
2	The PM has an adequate level of ability and experience to manage the project and project team <i>effectively.</i>		-
F: Commitment to safety			
1	The PM demonstrates a competent awareness of health and safety legislation and ensures the CDM		-
2	The PM promotes vigilant health and safety awareness within the project team, through both		-
Performance summary		Comments	Score
A: Quality of core services			-
B: Timely delivery of services/information			-
C: Commitment to key project objectives			-
D: Collaborative approach			-
E: Appropriate resourcing			-
F: Commitment to safety			-
G: Overall Performance			-
PM star rating		Comments:	

Survey of CA Performance



Assessor details		Project details:	
Partner role		LHB/Trust	
Co. name		Project no.	
Indiv. name		Project name	
Date		Project type	
		Project stage	
Score using the 1-10 scale.		Comments	Score
A: Quality of service			
1	The CA supports the PM in the running of the NEC		-
2	The CA ensures that risks are accurately quantified from a financial perspective.		-
3	The CA ensures that the financial aspect of change management is controlled and managed efficiently.		-
4	The CA produces accurate and relevant cost		-
5	The CA actively manages the costs on the project and produces reliable and accurate cost reports and cash flow forecasts, to ensure that the budget is maintained .		-
6	The CA produces documents to a high standard.		-
7	The CA drives the concept of "best value for money" through utilisation of VM and VE		-
8	The CA carries out valuations effectively and accurately values the works.		-
9	The CA facilitates the timely and accurate agreement of the final account .		-
10	The CA manages procurement and tendering processes effectively.		-
B: Timely delivery of services/information			
1	The CA efficiently manages their own time .		-
2	The CA delivers their documents and information		-
C: Commitment to key project objectives			
1	The CA appreciates the importance of maintaining the project programme and contributes to efforts to keep the project on track .		-
2	The CA ensures that appropriate cost control systems and reporting is carried out on a regular		-
D: Collaborative approach			
1	The CA understands their roles and responsibilities and those of others.		-
2	The CA shares information freely and communicates openly and honestly.		-
3	The CA actively contributes to collaborative and cooperative working throughout the team.		-
4	The CA proactively engages with the client in setting up and operating the Project Bank Account.		-
E: Appropriate resourcing			
1	The CA has adequate time to spend on the project and invests the necessary time to discharge their duties .		-
2	The CA has an adequate level of ability and experience to manage the project costs effectively.		-
F: Commitment to safety			
1	The CA demonstrates a competent awareness of the CDM regulations and is vigilant of health and safety issues through both design and construction activities .		-
Performance summary		Comments	Score
A: Quality of core services			-
B: Timely delivery of services/information			-
C: Commitment to key project objectives			-
D: Collaborative approach			-
E: Appropriate resourcing			-
F: Commitment to safety			-
G: Overall Performance			-
CA star rating		Comments:	

Survey of PD Performance



Assessor details		Project details:	
Partner role		LHB/Trust	
Co. name		Project no.	
Indiv. name		Project name	
Date		Project type	
		Project stage	
Score using the 1-10 scale.		Comments	Score
A: Quality of core services			
1	The PD ensures that the client and project team are fully aware of their duties under the CDM regulations.		-
2	The PD produces an accurate and bespoke set of Pre-construction Information.		-
3	The PD ensures that the F10 notice is issued in a timely manner and kept up to date.		-
4	The PD carries out a thorough review of the construction phase health and safety plan.		-
5	The PD advises the Client on the competency of the project team in connection with the CDM regulations.		-
6	The PD ensures that health & safety is accounted for in the design of the project.		-
7	The PD carries out regular site inspections and produces accurate reports during the construction		-
8	The PD thoroughly reviews the O&M manuals and produces an accurate and structured Health & Safety		-
9	The PD produces documents to a high standard.		-
B: Timely delivery of services/information			
1	The PD efficiently manages their own time.		-
2	The PD delivers their documents and information to programme.		-
C: Commitment to key project objectives			
1	The PD appreciates the importance of maintaining the project programme and contributes to efforts to keep		-
D: Collaborative approach			
1	The PD understands their roles and responsibilities and those of others.		-
2	The PD shares information freely and communicates openly and honestly.		-
3	The PD actively contributes to collaborative and cooperative working throughout the team.		-
E: Appropriate resourcing			
1	The PD has adequate time to spend on the project and invests the necessary time to discharge their		-
2	The PD has an adequate level of ability and experience to manage the health & safety aspects of the project effectively.		-
F: Commitment to safety			
1	The PD demonstrates a high level of awareness of health and safety legislation and ensures the CDM		-
2	The PD champions health and safety awareness within the project team, through both design and		-
Performance summary		Comments	Score
A: Quality of core services			-
B: Timely delivery of services/information			-
C: Commitment to key project objectives			-
D: Collaborative approach			-
E: Appropriate resourcing			-
F: Commitment to safety			-
G: Overall Performance			-
PD star rating		Comments:	



Adrian Crompton
Auditor General for Wales
Audit Wales
1 Capital Quarter
Cardiff
CF10 4BZ

By email

19 July 2024

Dear Adrian,

Community Pharmacy Data Matching Pilot

Thank you for your letter of 23 May and the accompanying report describing the findings and recommendations of Audit Wales' community pharmacy data matching pilot. Given the scale of public expenditure on medicines and pharmaceutical services, tackling fraud and error is of considerable importance and I am grateful to you and your colleagues for taking the time to investigate risk in the community pharmacy sector so thoroughly.

I am particularly pleased this extensive pilot involving almost 30% of pharmacies in Wales over a three-year period, found no evidence of systemic fraud or error. I consider these findings are likely to be representative given the large sample size, the mix of pharmacies and prescriptions dispensed in the sample, and the duration of the field work. The report therefore provides welcome assurance in this area of high spend and scrutiny.

Whilst not making specific recommendations, you ask three questions NHS Wales, should ask itself, given the findings of your pilot.

Are you satisfied with the current approaches in each health board, and across NHS Wales, to identify and investigate outliers in relation to high cost and risk of fraud for dispensing contractor activity?

As I have set out above the report provides a great deal of reassurance that auditors were unable to find any evidence of systemic fraud or error within the community pharmacy

Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.



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sector. Of course, we cannot be complacent given there may be some types of fraudulent activity which were not investigated by the pilot or fraud may be occurring in health boards other than those included in the sample.

There are examples of significant fraudulent practice having occurred in the community pharmacy sector such as those described in the report. It is reassuring that these historic cases were identified by health boards working closely with NHS Counter Fraud Services, through checks and balances which pre-date the pilot.

The pilot identified risks in three main areas: pricing errors, expensive items and specials.

On pricing errors, between 6 million and 7 million prescriptions in Wales are processed for payment by the NHS Wales Shared Services Partnership every month. Prescription payment accuracy is consistently high with an error rate of only around 1 per 1000 prescriptions processed. Where processing errors occur, they are as likely to result in underpayments to pharmacies as they are in overpayment by the NHS. Audit Wales' work only considered overpayments and it is therefore likely that further investigation of errors would cancel out any potential savings for the NHS over time. The level of pricing accuracy is agreed between the NHS and Community Pharmacy Wales on behalf of pharmacy contractors we do not therefore propose to take any further actions to address under and overpayments. It will however remain possible to make corrections in respect of individual errors on an ad hoc basis.

Turning to expensive items, I agree additional checks by health boards are likely to improve how risks are managed in this area. Whilst I am aware health boards may undertake some checks on expensive prescriptions already, such checks generally focus on the prescriber of the medicine rather than the pharmacy which dispensed it. I agree with your assessment that health boards would have greater assurance if additional checks on pharmacies dispensing large numbers of expensive prescriptions were undertaken. We will therefore take three actions to improve the work health boards undertake in this area.

Firstly, we have commissioned the Wales Analytical Prescribing Support Unit (WAPSU) to develop an interactive expensive items dashboard which can be accessed by health boards and used to identify expensive prescriptions issued by general practitioners and hospital outpatient departments in their area. The dashboard allows health board users to access aggregated and individual prescription data including the individual prescription images retained by the NHS Wales Shared Services Partnership.

Secondly, we will work with the NHS Wales Shared Services Partnership to develop a monthly report detailing expensive items dispensed by pharmacies in each health board area and make this report routinely available to health boards.

Finally, we will write to health boards providing information about both the interactive dashboard and the community pharmacy expensive items report, asking them to confirm what arrangements they will put in place to ensure the new tools are used to minimise the risk of fraud or error occurring within the health board.

Are key lessons and best practice around these matters being shared between health boards? For example, are the health boards sharing examples of where fraud has been identified to make them aware of risks?

I agree there are likely to be significant benefits arising from sharing lessons learned and best practice between health boards. We will therefore write to the Head of NHS Counter Fraud Services in Wales and the Directors of Pharmacy of each health board asking what arrangements might be put in place to facilitate such information sharing.

Is there scope for the NHS in Wales to put extra cost-effective controls in place around the variable costs of specials?

Specials are often considerably more expensive than licenced medicines, due to the bespoke nature of the product and include costs of sourcing raw materials, manufacturing, quality control, or importing products and distribution.

The nature of specials make them much more liable to price fluctuations arising from changes to the prices of raw materials or from an urgent need for a special to be manufactured where a surcharge may be payable for faster delivery.

Action has been taken over a number of years to reduce the cost of specials to the NHS. In 2011, standard reimbursement prices were introduced for the most commonly prescribed manufactured specials (for example liquids, creams and ointments made to an individual formula). Between 2018 when Audit Wales began its fieldwork, and 2023 the total annual spend on these medicines fell by more than 50% (from £1.01 to £0.48m per year) as a result of the changes.

More recently in March 2022, further changes were made to reduce the cost of unlicensed, imported medicines by incentivising pharmacy contractors to source these medicines at the cheapest price possible, reducing variation and excessive prices that do not reflect the cost of manufacturing the special. In the first year following these further changes costs fell by 5% (from £0.65m to £0.62m).

The reimbursement costs of specials have been subject to scrutiny for a number of years including as part of a Department of Health and Social Care [consultation](#) in 2019. Various approaches including requiring pharmacy contractors to obtain quotes from several manufacturers, seeking central approval to place orders, and a national specials' procurement service, have all been proposed and discounted as being unlikely to result in significant cost savings.

Given the changes made since Audit Wales' fieldwork, the previous consultation and analysis of options, and the significant reduction in cost in recent years, I do not consider the same potential exists to make the savings estimated by Audit Wales in future years. However, there continues to be potential for health boards to review individual prescriptions for high cost specials which could be replaced with a lower cost standard licensed preparation. The interactive expensive items dashboard developed by WAPSU will support health boards to identify additional opportunities to query the prescribing of expensive unlicensed specials.

I trust this information demonstrates the steps we are taking to ensure fraud is identified and wherever possible prevented in the community pharmacy sector in Wales. The additional actions we will take as a direct result of the data matching pilot will serve to strengthen health boards' approach further and I am grateful to you and your colleagues for your interest and assistance in this important area.

I am copying this letter to the Chairs of Senedd Cymru's Public Accounts and Public Administration Committee, Health and Social Care Committee, and Finance Committee, for information.

Yours sincerely



Andrew Evans FRPharmS
Prif Swyddog Fferyllol/Chief Pharmaceutical Officer
Llywodraeth Cymru/Welsh Government