Audit Risk and Assurance Committee

Tue 12 September 2023, 09:30 - 12:30

Microsoft Teams

Agenda

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 18th July 2023

Attachment *Chair*

1.4 Draft ARAC Minutes 18 July 2023 RD_IJ Approved.pdf (8 pages)

1.5. Committee Action Log

Attachment *Chair*

1.5 Draft Audit Risk Assurance Committee Action Log July 2023 .pdf (3 pages)

2. Items for Approval/Ratification/Decision

2.1. Report on the use of Single Tender Action

Attached *Director of Finance and Procurement*

2.1 Single Tender Action Report 12.09.2023.pdf (3 pages)
2.1a Appendix A v2- STA Summary March 24th 2023 - Aug 30th 2023.pdf (1 pages)

2.2. Ratification of Financial Governance, Reporting and Control Procedures, including;

Attached *Director of Finance and Procurement*

- Procurement Policy
- Prepayment of Goods and Services

2.2 Governance Report 12.09.2023.pdf (8 pages)
2.2a Appendix 1 ABUHB_Finance_0993 Procurement Policy FINAL (003).pdf (9 pages)

3. Items for Discussion

3.1. Review of Committee Programme of Business

Attached *Director of Corporate Governance*

3.1 MASTER_ARA_Committee Work Programme 2023-24. Final.pdf (5 pages)

3.2. Annual review of Committee Effectiveness 2023/24

Attached *Director of Corporate Governance*

3.2 ARAC_Self Assessment of Committee Effectiveness Cover Report.pdf (4 pages)
3.2a Appendix 1Audit Committee Self Assessment Template.pdf (11 pages)

3.3. Review of Audit Recommendations Tracking

Attached *Director of Corporate Governance*

3.3 Internal_External Audit Recommendations Q1 22_ 23 Cover Report ARAC..pdf (8 pages)
3.3a Appendix 1 Overdue IA Recommendations Without a Revised Deadline.pdf (10 pages)
3.3b Appedix 2 IA Recommendations Revised Deadlines.pdf (6 pages)
3.3c Appendix 3 IA and EA Completed Reccommedations in Q1 2022-23.pdf (11 pages)
3.3d Appendix 4 Overdue EA Recommedations Without a Revised Deadline.pdf (2 pages)
3.3e Appendix 5 EA Recommendations Revised Deadline.pdf (1 pages)
3.3f Appendix 6 Not Yet Due Recommendations.pdf (14 pages)

3.4. Committee Risk and Assurance Report

Attached *Director of Corporate Governance*

3.4 ARAC_Update Report on the Refreshed Risk Management Approach _Sept 2023.pdf (5 pages)
3.4a Appendix 2 Example Risk to a Page_SRR 008_Financial Sustainability_Director of Finance.pdf (1 pages)
3.4b Appendix 1 Risk management Realisation Plan July 2022.pdf (6 pages)

3.5. Internal Audit Progress Report

Attached *Deputy Head of Internal Audit, NWSSP*

3.5 ABUHB September 2023 Audit Committee Progress Report for issue.pdf (7 pages)

3.6. Receive Internal Audit Reports;

3.6.1. Bank Office and Temporary Staff

Attached *Deputy Head of Internal Audit, NWSSP*

3.6 ABUHB 2022-23 Bank Office Final Internal Audit Report for Client.pdf (18 pages)

3.6.2. IMTP

Attached *Deputy Head of Internal Audit, NWSSP*

3.6a ABUHB 2324-08 IMTP Final Internal Audit Report client issue.pdf (15 pages)

3.6.3. Safeguarding

Attached *Deputy Head of Internal Audit, NWSSP*

3.6b AB-2324-11 Final Safeguarding Report for Client.pdf (15 pages)

3.7. External Audit Progress Report

Attached *Performance Audit Lead, Audit Wales*

3.7 Audit Risk and Assurance Committee Update - September 2023.pdf (12 pages)

4. Items for Information

There are no items for inclusion in this section.

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 28th November 2023

Oral *Chair*

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

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

DATE OF MEETING	Tuesday 18th July 2023
VENUE	Microsoft Teams

PRESENT	Iwan Jones - Independent Member, Committee Chair Paul Deneen - Independent Member Shelley Bosson - Independent Member
IN ATTENDANCE	Rob Holcombe - Director of Finance and Procurement Rani Dash- Director of Corporate Governance Mark Ross - Assistant Finance Director Gareth Lewis – Assistant Head of Financial Services and Accounting Michelle Morris – Head of Counter Fraud Leeanne Lewis – Assistant Director of Patient Quality & Safety Stephen Chaney - Acting Head of Internal Audit, NHS Wales Shared Services Partnership (NWSSP) Andrew Doughton - Audit Manager (Performance), Audit Wales Neall Hollis - Audit Manager (Finance), Audit Wales Tracy Veale – Audit Lead (Finance), Audit Wales Cai Hale – Senior Auditor, Audit Wales Alexis Smith – Senior Auditor, Audit Wales Bryony Codd – Head of Corporate Governance Lucy Windsor - Committee Secretariat
APOLOGIES	Nicola Prygodzicz - Chief Executive Richard Clark (Vice Chair) – Independent Member

ARA 1807/1	**Preliminary Matters**
ARA 1807/1.1	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
ARA 1807/1.2	**Apologies for Absence** Apologies for absence were noted.
ARA 1807/1.3	**Declarations of Interest** There were no declarations of interest raised to record.

ARA 1807/1.4	**Minutes of the previous meeting** The minutes of the meeting held on the 23rd May 2023 were agreed as a true and accurate record. One point of accuracy was noted in the designation of Richard Harries. The title to be changed to Engagement Director. **Action**: **Secretariat**
ARA 1807/1.5	**Committee Action Log** The Committee received the action log. Members were content with progress made in relation to completed actions and against any outstanding actions.
ARA 1807/2	**Items for Approval / Ratification/ Decision**
ARA 1807/2.1	**Clinical Audit Plan 2023 -24** On behalf of the Medical Director, Leeanne Lewis (LW), Assistant Director of Patient Quality & Safety, presented the Clinical Audit Plan 2023/24. LW informed the Committee that a clinical audit plan for the next 12-24 months had been developed in collaboration with clinicians. Local audits for adding to AMAT had been mandated, and the AMAT system had been implemented and was being used throughout the organisation. The plan was approved by the PQSOC at its meeting on 20th June 2023. Ward Assurance Audits had started; a completed audit would be included within the activity update scheduled for the Committee meeting in February 2024 for information. **Action: Assistant Director of Patient Quality and Safety** The Committee noted that supporting policies and strategies would be updated to ensure that all available resources would be used to ensure effective clinical audit management. The Committee **RATIFIED** the Clinical Audit Plan 2023/24. *LW left the meeting*.
ARA 1807/3	**Items for Discussion**
ARA 1807/3.1	**Quarterly Update on Counter Fraud Activity** Michelle Morris (MM) Head of Counter Fraud provided the Committee with an update on Counter Fraud activity in Quarter 1 of the 2023/24 financial year.

	The Committee expressed concern about the number of staff who completed the ESR eLearning programme for Counter Fraud and requested more information about the actions taken to address the low uptake. MM responded that work was being undertaken with the Workforce & Organisational Development (W&OD) Team and that a Core Learning Committee had been formed to review and approve the addition of statutory and mandatory training. Rani Dash (RD), Director of Corporate Governance, confirmed that the Core Learning Committee, which would review all applications for mandatory training and classify them based on priority and impact, would report to the People and Culture Committee to provide assurance on committee activity and outcomes. Rob Holcombe (RH), Director of Finance and Procurement, asked the Committee to support the application to the Core Learning Committee to make Counter Fraud training mandatory. The Committee agreed to support the application, and its endorsement to be included in the application. The Committee noted from the Thematic Report that the Health Board along with WAST (Welsh Ambulance Services NHS Trust) were the only 2 organisations in Wales to achieve the required standards. The Committee **NOTED** the Report for assurance.
ARA 1807/3.2	**Internal & External Audit Recommendations Tracker** Rani Dash (RD) Director of Corporate Governance, provided an update on the Tracker as at the end of the financial year 2022/23. The Committee was informed that some additional work was required to mature the reports in terms of providing detail related to agreed and revised timeframes. The request to move to quarterly reporting would allow reports to focus on areas where there had been a lack of progress and implementation since the original recommendation's acceptance. The Committee agreed to quarterly reporting but stated that it would reconsider if the quality of the updates deteriorated, and it could not derive an acceptable level of assurance from the information provided.

	RD agreed to continue reporting on long-standing actions until the Tracker was in a balanced position; where necessary, the Lead Director would be invited to explain why long-standing recommendations had not been progressed. Any recommendations with a start date of April 2023 or later would be reported quarterly. The Committee requested that the information in the spreadsheets be reviewed to make the key points easier to read. The full spreadsheet would be shared to ensure openness in terms of access, but future reporting would be reframed to ensure relevant detail is the focus of the report. **Action: Head of Risk & Assurance** The Committee welcomed the continued progress in performance within the tracker, recognising the further work required. The Committee **APPROVED** the revised dates and the transition to quarterly reporting on the condition that all longstanding recommendations were completed or given revised deadlines.
ARA 1807/3.3 & 3.4	**Audit Progress Reports** Stephen Chaney (SC), Acting Head of Internal Audit, NWSSP, provided an update to the Committee on the status of reviews, advising that the audit plan for 2023/24 was on track. SC informed the Committee that a request to defer Job Planning to Quarter 4 (Q4) 2023/24 had been received to allow ongoing work to address previous recommendations. The Committee approved the request to postpone the internal audit until Q4, on the condition that an assurance note and those in charge of implementing the system attend the November 2023 meeting to provide an update on progress and assurance on how the controls would be improved, with a full report to the Committee in February 2024. **Action: Secretariat** Further requests for additional audits were noted as follows: • Q2 - Facilities Rostering • Q2 - Regional Partnership Board (RPB) – Financial Governance Arrangements

	RD advised that the RPB had recently commissioned an independent governance review spanning all its governance arrangements, and the report was due late summer, so the internal review would be better completed in Q4 to avoid duplication of effort but could be used as a follow-up review to the independent review. In respect of the 2022/23 Audit Plan the Committee received the following Reasonable assurance reports: • Clinical Futures – Care Closer to Home • Infection, Prevention, and Control • Integrated Wellbeing Networks • Dementia Services • Contract Management • Mental Health Transformation The Committee **NOTED** the Internal Audit Progress Reports and **ENDORSED** the changes to the Internal Audit Plan for 2023/24.
ARA 1807/3.5	**Annual Head of Internal Audit Opinion** Stephen Chaney (SC), Acting Head of Internal Audit, NWSSP, informed the Committee that the overall outcome of the report was reasonable assurance, noting that 6 limited, 18 reasonable, and 3 substantial assurance reports were issued throughout the audit year 2022/23. The Committee was informed that Internal Audit was currently compiling a report with frequently identified common themes and recommendations across the Health Board and other client organisations. Once completed, the analysis would be shared with the Committee. The Committee **NOTED** the Annual Head of Internal Audit Opinion.
ARA 1807/3.6	**External Audit Progress Report** Andrew Doughton (AD), Audit Lead (Performance) provided an overview of the report. The Committee noted that the Structured Assessment fieldwork would begin in mid-September, and the Workforce Planning Review would likely be delayed past the original September 2023 start date.

	Members were assured that the audits of the Charitable Funds would meet statutory deadlines, but a timetable for the work to begin could not be provided at this time. The Committee **NOTED** the External Audit Progress Reports
ARA 1807/3.7	**Review of the Draft Annual Report 2022/23, including: Performance Report (Part 1) and Accountability Report (Part 2)** Rani Dash (RD), Director of Corporate Governance, provided an overview of the final reports, highlighting that the Committee's requested changes had been implemented and were attached for reference. Since the distribution of the Committee papers, a few administrative errors had been identified, which RD informed had been corrected for the Board meeting scheduled for Wednesday 19th July 2023. The Committee noted that the Performance Report and Accountability Report (which included the corporate governance report, remuneration, and staff report) detailed the Health Board's performance over the previous year and met the guidance set out in the Manual for Accounts. The Committee received the reports and **ENDORSED** the contents for approval by the Board.
ARA 1807/3.8	**Review of the Draft Financial Statements 2022/23 (Part 3), including: Annual Accounts 2022/23** Mark Ross (MR), Assistant Finance Director, provided an overview of the report, noting that a few minor queries about potential misstatements would have been resolved completely or substantially since the report was submitted to the Committee. There had been a few minor changes to the classification since the Committee received the draft accounts in May 2023, but these had no effect on financial performance. The Committee noted the inclusion of a paragraph relating to the Health Board's position on its financial duty to break even, which Audit Wales confirmed had been sighted on. The Committee received the report and **ENDORSED** the contents for approval by the Board.

ARA 1807/3.8b	**Audit of Accounts (ISA 260) including Letter of Representation** Tracy Veale (TV), Audit Lead (Finance), provided an overview of the report noting the accounts were substantially complete and since submitting the report had received assurances from the external management expert on the work of the District Valuer. Audit Wales intended to issue an unqualified opinion on the financial statements but would qualify the regularity opinion because the Health Board had not met its first financial duty of breaking even over the three-year period. In respect of points that needed to be brought to the attention of those in charge of governance, some misstatements had been corrected, and the few remaining areas where misstatement was possible were below materiality levels. Furthermore, potential errors in the remuneration report were material in nature but were noted due to significant issues with the recommendations. The date on which the Auditor General would sign the accounts was misrepresented in the report; the date would be Tuesday 25th July 2023. The opinion and Senate report would be updated to reflect the new date. The Committee **NOTED** the Audit of Accounts and would **RECOMMENDED** that the Board sign the Letter of Representation.
ARA 1807/3.9	**Recommendation to the Board in respect of the Annual Report and Accounts 2022/23** The Audit, Risk and Assurance Committee recommended that the Board: • **RECEIVE** the Audit of Accounts Report (2022/23) of External Audit (Audit Wales) • **APPROVE** the Annual Report and Accounts 2022/23, 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.
ARA 1807/4	**Items for Information**
	No items received.
ARA 1807/5	**Other Matters**
ARA 1807/5.1	There were no matters arising. The Chair on behalf of the Committee thanked Paul Deneen, Independent Member for his tenure and contribution to the Audit, Risk & Assurance Committee.
ARA 1807/3.2	**Date of the next meeting; -** • Tuesday 12th September 09:30 – 12:00

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
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
Dec 2022	**ARAC0112/03** Consultant Job Planning	Following the implementation of the automated job planning process an update report is to be received at a future meeting to close off Audit Recommendations.	Secretariat / Medical Director	**08 February 2024**	**Not Due** Due to the Audit, Risk and Assurance Committee's 2023/24 schedule, an update has been scheduled for February 2024. This ensures enough time between implementation and progress to be reported. The People and Culture Committee will receive an update on progress at its meeting on, 18th October 2023.

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 2023	**ARA1807/3.3** Internal Audit Progress Report Consultant Job Planning	An assurance note and those in charge of implementing the Job Planning system to attend the November 2023 meeting to provide an update on progress and assurance on how the controls would be improved, with a full report to the Committee in February 2024.	Medical Director / Director of Workforce & OD	**November 2023**	
April 2023	**ARAC1804/14** Strategic Risk & Assurance Report	An update on the new risk **CRR046 -** Reinforced Autoclaved Aerated Concrete (RAAC) within structures to be obtained from the Planning Team and circulated to Committee Members.	Director of Strategy, Planning and Partnerships	**23 May 2023**	**Completed.** The Director of Strategy, Planning & Partnerships provided an update to the Board in a private session in July 2023.
July 2023	**ARAC1807/2.1** Clinical Audit	A completed Ward Assurance Audit to be included within the activity update scheduled for	Medical Director	**February 2024**	

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		the Committee meeting in February 2024 for information.			
	ARAC1807/3.2 Internal & External Audit Recommendations Tracker	The Tracker is to be condensed in future reporting to ensure relevant detail is the focus of the report.	Director of Corporate Governance	**September 2023**	**Completed.** The report has been refined to ensure the Committee has the key information to discharge its responsibilities.

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 2023
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	**Update on Single Quotation and Tender Actions –24th March 2023 – 30th August 2023**
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	**Rob Holcombe, Director of Finance, Procurement and Value Based HealthCare**
SWYDDOG ADRODD: REPORTING OFFICER:	**Katy Jones – Deputy Head of Procurement**

Pwrpas yr Adroddiad Purpose of the Report
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 24th March 2023 – 30th August 2023
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 5 requests submitted which have been approved during the period with an annual value of £238,038.80 Ex VAT.

The largest of these relates to £130k fully kitted out mobile unit to maintain service of endoscopy decontamination whilst new endoscopy unit is being built in RGH.

Of these 5 approved requests, 2 were classified as either licensing or maintenance/ service type arrangements. There were 3 classified as goods purchased.

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

Appendix A - Summary of Single Tender/Quotation Actions

Date of Request	Type of Request	Reference No	Description	Anticipated Annual Value (ex VAT)	Supplier	Type	Reason for request	Advice from Procurement	Approved / Rejected	CEO Approval Date	Chairs Approval Date (If Applicable)
24/03/2023	Single Tender Action	ABU-STA-52928	Bariatric operating Trolley	£8,160.00	Labmed	Goods	Specialist bariatric trolley for opthalmology proceedures. The division previously has been spending revenue for a loan trolley to undertake a backlog of bariatric patients. There is no alternative equipment available which is suitable for ophthalmic theatre cases. Capital funding was approved as this is more cost effective than repeating a 3 month hire which would need to be repeated in an ongoing manner. Purchasing outright would save £8840 in revenue	With research this is the only supplier that can fulfil	Approved	24/03/2023	
24/03/2023	Single Tender Action	ABU-STA-52881	Nitrous Oxide Machine	£37,378.80	Medclair	Goods	There is currently no active scavenging of expired Entonox at the Grange University Hospital and whilst its use should be confined to clinical areas with appropriate ventilation systems, there is still likely to be an increased exposure for staff working in these areas. No date has been agreed for commencement or completion of work in GUH as yet, so in the meantime capital funding has allowed purchase of an Entonox Nitrous Oxide Destruction mobile unit - this will improve the Nitrous Oxide Levels in the labour ward environment in GUH. The mobile unit will monitor ambient Nitrous Oxide levels in delivery rooms while Entonox is in use until work can be completed on a bigger scale	With research this is the only supplier that can fulfil	Approved	13/03/2023	
17/04/2023	Single Tender Action	ABU-STA 53111	Mobile Decontaminatio n Unit - Edoscopy RGH	£130,000.00	Getinge	Goods	There is a requirement for a fully kitted out mobile unit to maintain the service of endoscopy decontamination whilst the new endoscopy unit is being built in RGH. This mobile unit will provide the equipment which will subsequently be moved in to the new unit when completed in 2024 and staff will be trained here also.	Gettinge awarded overall contract of new decon unit and this unit will contain a lot of new equipment while unit being built	Approved		17/04/2023
17/04/2023	Single Tender Action	ABU-STA-53109	Arts Strategy for Radiotherapy Satellite centre NHH	£25,000.00	Studio Respons e	Service	The Radiotherapy Satellite Centre build at Nevill Hall is an outreach unit of Velindre Cancer Centre The RSC and the new VCC are by design required to operate as 'one service, two sites' and maintain the Art experience of the Velindre Radiotherapy Service on the Nevill Hall Site. To facilitate this outcome, there has been significant engagement between the two schemes and it is proposed that a single Arts Management Service Provider would facilitate the seamless delivery of the Arts Programme. It would also offer economies of scale by utilising work already undertaken and potential facilitating common commissions across both sites.	Maintain continuity of supply of Arts throughout the sites	Approved	17/04/2023	
18/08/2023	Single Tender Action	ABU-STA-54286	Continuation of Peer Mentors Service	£37,500.00	Growing Space	Service	The Peer Mentors were based within Crisis Liaison Team and worked closely within the ED on a pilot scheme supporting patients in crisis. This pilot, demonstrated extremely positive feedback and impact within the ED (operated under Urgent Care). Peer Mentors had a significant impact on people presenting at the ED (Urgent Care), the pilot was reconfigured to accommodate more people The Peer Mentors engaged with and supported patients referred into their service to re-connect with the community with the intention of preventing those patients from reaching crisis/reduce re-occurrence of crisis. Therefore, the service was truly preventative and hand held people into emotional/social support services. STA approved for extension of service from 1st April 2023 – 31st August 2023 (five months)	The only supplier in the market to meet the unique requirements.	Approved	21/03/2023	
				£238,038.80							

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	12 September 2023
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Financial governance, reporting & control.**
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	**Rob Holcombe, Director of Finance, Procurement and Value Based HealthCare**
SWYDDOG ADRODD: **REPORTING OFFICER:**	**Estelle Evans, Head of Financial Services and Accounting**

Pwrpas yr Adroddiad
Purpose of the Report

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.

The Audit, Risk and Assurance Committee is requested to:

- Note the contents of this report.

- Approve the amendments to the following financial control policy and procedure.

- Procurement Policy (Appendix 1)
- Prepayment of Goods and Services procedure

Cefndir / Background

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

The FCPs presented have been reviewed by the Executive Committee and are presented to the Audit, Risk and Assurance Committee for approval.

A table has also been included to provide an update of the action taken to date to ensure compliance with the review date for 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:

- Procurement Policy (Appendix 1)
- Prepayment of Goods and Services procedure

These policy/procedures were presented and approved at the Executive Committee on 24th August 2023.

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

Procurement Policy

Owner: Director of Finance, Procurement and Value
Review Date: July 2023

The procurement of goods and services is a key process supporting the delivery of high-quality patient care whilst ensuring value for money is achieved.

Standing Financial Instructions (SFIs) set out procurement principles and duties of managers with delegated authority to commit expenditure on behalf of Aneurin Bevan University Health Board (ABUHB).

The purpose of this document ensures that the underlying aims of public procurement – to ensure accountability in the public sector and transparency in decision making – are met.

The document has been circulated for comment as follows:

- Procurement Business Manager – Sourcing
- Assistant Head of Operational Procurement - Sourcing
- Head of Financial Services and Accounting
- Head of Business Systems and Governance
- NWSSP - Audit and Assurance Services

Main changes to the document

Paragraph	Summary of Changes
All	Organisational change – Director of Finance changed to Director of Finance, Procurement and Value.
All	Intranet links added for internal documents.
5	Scope – Contract Management Procedure reference updated to identify that the policy has been drafted and in the process of being approved.
6	Roles and Responsibilities – Reference and link to 'The Procurement Manual@ added.
7.1	Procurement Principles – Name change from 'The procurement process is a formal process governed by European and UK legislation' to 'The procurement process is a formal process governed by Public Contract Regulation.'

Prepayment of Goods and Services

Owner: Director of Finance, Procurement and Value
Review Date: July 2023

The Prepayment of Goods and Services procedure was created in July 2020 relating specifically to the Covid-19 pandemic. It was written in response to the Welsh Government guidance: Covid-19 Decision Making & Financial Guidance (dated 30th March 2020).

The FCP was created to ensure that prepayments could be made to certain suppliers to maintain uninterrupted supply of vital goods and services for the provision of health care and designed to support the Management and Strategic Command Structure set up during that time.

Prepayments are covered under Section 10.6 of the SFIs

10.6.1 Prepayments should be exceptional, and should only be considered if a good value for money case can be made…

10.6.2 In exceptional circumstances prepayments can be made subject to:

a) The appropriate Executive Director providing, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the LHB if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments.

b) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the Public Contracts Regulations 2015 where the contract is above a stipulated financial threshold); and

c) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

Recommendation: The Prepayment of Goods and Services FCP is discontinued as the document was created specifically during Covid-19 and references decision processes that are no longer in place. The current SFIs are available on the intranet.

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
Capital Procedures and Guidance Notes	23/24	Overdue	Apr-20	02-Apr-23	Scheduled for Nov 23
Procurement Policy	23/24	Due for review	Jul-20	13-Jul-23	Scheduled for Sep 23
Prepayment of Goods and Services	23/24	Due for review	Jul-20	13-Jul-23	Scheduled for Sep 23
Patients' Travel Costs Policy	23/24	Y	Oct-20	22-Oct-23	
Cash and Bank	23/24	Y	Oct-20	22-Oct-23	
Petty Cash	23/24	Y	Dec-20	03-Dec-23	
Petty Cash - Mental Health	23/24	Y	Dec-20	03-Dec-23	
Accounts Receivable	23/24	Y	Feb-21	04-Feb-24	
Approval of Orders over £100K	23/24	Y	Feb-21	04-Feb-24	
Salary Sacrifice	24/25	Y	Aug-21	12-Aug-24	
Policy for Out of Area Referrals to Secondary Care	24/25	Y	Aug-21	12-Aug-24	
Overseas Visitors	24/25	Y	Feb-22	03-Feb-25	
Charitable Funds	25/26	Y	Apr-22	19-Jul-25	
Recovery of Overpayments to Employees	25/26	Y	Aug-22	02-Aug-25	
Budgetary Control Policy & Procedure	25/26	Y	Aug-22	02-Aug-25	
Losses and Special Payments	25/26	Y	Oct-22	06-Oct-25	
Stores & Stocks	25/26	Y	Oct-22	06-Oct-25	
Counter Fraud Bribery and Corruption Policy	25/26	Y	Oct-22	25-Nov-25	
Capital Assets and Charges	25/26	Y	Dec-22	01-Dec-25	
Engaging Off Payroll Workers	25/26	Y	Feb-23	02-Feb-26	
Accounts Payable	25/26	Y	Feb-23	02-Feb-26	
Patients' Property	25/26	Y	Feb-23	02-Feb-26	
Purchasing Cards	25/26	Y	Feb-23	02-Feb-26	
General Ledger	26/27	Y	Apr-23	18-Apr-26	
Policy and Governance approach for Commissioning Additional (External & Insourced) Non NHS Clinical Services	26/27	Y	Apr-23	18-Apr-26	

2. Technical Accounting Issues

2.1 Technical updates

There have been no technical accounting updates issued by Welsh Government since the end of 2022/23.

4. Public Sector Payment Policy (PSPP)

The following table shows the Public Sector Payment Policy performance for the month of July 2023 and on a cumulative basis.

Category	Invoices	In Mth %	YTD %
NHS	Value Number	93.6 84.5	92.1 88.3
Non NHS	Value Number	97.4 97.0	96.8 96.8

On a cumulative basis the Health Board have achieved 96.8% compliance of the number of non-NHS creditors paid within 30 days which is slightly above the required performance target.

With regard to the NHS percentage the Health Board percentage achieved is below the 95% target with 84.2% achieved in month and 88.2% on a cumulative basis.

The Table below shows the number and value of both Non-NHS and NHS invoices processed in 2022-23 and April-July 2023-24 by the Health Board and the percentage of invoices that were paid within 30 days of delivery.

Public Sector Payment Policy(PSPP) - Compliance

	2023-24 Apr-July	2023-24 Apr-July	2022-23	2022-23
	Number	£000	Number	£000
NHS				
Total bills paid	1,637	127,615	4,740	380,000
Total bills paid within target	1,445	117,568	4,198	360,894
Percentage of bills paid within target	88.3%	92.1%	88.6%	95.0%
Non-NHS				
Total bills paid	113,538	241,977	371,943	651,605
Total bills paid within target	109,882	234,168	354,020	624,146
Percentage of bills paid within target	96.8%	96.8%	95.2%	95.8%
Total				
Total bills paid	115,175	369,592	376,683	1,031,605
Total bills paid within target	111,327	351,736	358,218	985,040
Percentage of bills paid within target	96.7%	95.2%	95.1%	95.5%

NHS invoices

We are contacting the requisitioners concerned to establish the cause for the delay in payment and to put processes in place to ensure achievement of the 95% target going forward. Below is the action taken to date to improve the percentage achieved in line with the target.

- April – June NHS PSPP breaches have been reviewed and the requisitioner identified.
- An email has been sent to each requsitioner informing them that:

- they are in breach of Health Board procedures.
- asking them to ensure that going forward they raise an order prior to receiving the goods/services or invoice.
- identifying the types of orders, they can raise e.g., call off order for secondments, estimated order where the value is unknown etc.
- Offering help and support/training if they are unsure how to raise the appropriate order.

- NHS breaches will be monitored monthly and requsitioners contacted.

- Escalation to senior managers will be implemented for those who continually breach the Health Board procedures and do not take the appropriate action to with regarding to raising a Purchase Order and making the supplier aware of the PO number at the time the goods/services are requisitioned.

- All NHS bodies will be contacted to reiterate that ABUHB are a No PO No Pay Health Board and that they require a PO from the HB prior to providing any goods or services.

5. Payments in Excess of £100K

There were no exceptional issues to report.

6. Standing Financial Instructions

These have been reviewed on an all Wales basis and some changes have been made to the model version and will be presented to the Board in September. The changes are minor in nature and largely relate to clarification of responsibilities for signing the annual report and accounts and procurement consent for contracts and frameworks entered into by Health Education Improvement Wales and NWSSP Procurement Services.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is requested to approve the amendments to the following procedures.

- Procurement Policy
- Prepayment of goods and services procedure – to be discontinued

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 3.5 Record Keeping Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Finance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	FCP – Financial Control Procedure PO – Purchase Order PSPP – Public Sector Payment Policy
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	**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

Procurement Policy

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

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

Issue date: DRAFT
Review by date: DRAFT
Policy Number: ABUHB/Finance/0993

Contents:

1. Introduction

The procurement of goods and services is a key process supporting the delivery of high quality patient care whilst ensuring value for money is achieved. Standing Financial Instructions (SFIs) set out procurement principles and duties of managers with delegated authority to commit expenditure on behalf of Aneurin Bevan University Health Board (ABUHB).

2. Policy Statement

The Health Board is committed to ensuring that the purchase of all goods and services are properly authorised and comply with the requirements as set out in the Treasury rules on public procurement.

Procurement Services (part of NHS Wales Shared Services Partnership-NWSSP-PS) provide a comprehensive service to ABUHB, focusing on value, safety, excellence, innovation and quality. NWSSP-PS maintain and follow comprehensive procedures which complement and supplement the SFIs and encompass all aspects of procurement.

NWSSP-PS source and supply the Health Board with products and services through collaboration with their customers and partners allowing ABUHB staff to focus on patient care. Managers must be aware of their duties and responsibilities in relation to the procurement of goods and services and seek advice from the NWSSP-PS where individual purchases reach procurement thresholds as set out in Table 1 below.

3. Aims

The purpose of this document ensures that the underlying aims of public procurement, 'to ensure accountability in the public sector and transparency in decision making,' are met.

It also aims to provide guidance on procurement thresholds and good practice in the ordering of goods and services to support high quality patient care in ABUHB.

4. Objectives

- To outline procurement principles
- To outline the Health Board's delegation of authority
- To explain the No PO no Pay policy and how it affects ordering goods and services
- To provide guidance to users on ordering goods and services on behalf of ABUHB

5. Scope

This policy relates to the purchase of all goods and services and therefore affects:

- All staff who requisition goods
- All authorisers
- Staff involved in procuring services including engaging agency workers and other workers in an off payroll capacity.
- Health Board staff involved negotiating and awarding contracts for services on behalf of ABUHB.

Separate NWSSP-PS procedures are in place for tendering and contracting so are not covered in detail in this document. Please contact NWSSP-PS for advice and support.

Note that a separate Contract Management Policy has been drafted and in the process of being approved.

6. Roles and Responsibilities

The Chief Executive of ABUHB is responsible for ensuring procurement procedures are in place.

The Director of Finance, Procurement and Value is responsible for putting in place financial procedures to ensure that goods and services are duly authorised and comply with the Scheme of Delegation, which sets out authority delegated by the Chief Executive and can be found in Section 7.2 below.

Authorising staff are responsible for ensuring that they only approve goods and services in line with their service plans and within their delegated limits.

Requisitioning staff must attend training before accessing the Oracle system. They must have an understanding of procurement principles as set out in section 7 of this document.

NHS Wales Shared Services Partnership – Procurement Services are responsible for establishing tendering and contracting processes and procedures in line with best practice and legislation. They are also responsible for providing support and advice to ABUHB on the purchase of all goods and services where required.

A comprehensive Procurement Manual is available to support staff with procurement requirements.

7. Procurement

7.1 Procurement Principles

The procurement process is a formal process governed by Public Contract Regulations.

NHS Wales Shared Services - Procurement services are involved in the complete process from early involvement in identifying requirements, identifying the most appropriate procurement strategy, leading the procurement process and supporting contract managers to ensure the successful delivery of all works, goods and services required.

ABHUB SFIs provide further detail on Welsh Government procurement requirements.

7.1.1 Procurement Thresholds

Table 1 procurement thresholds (Extract from SFIs)

Contract Value (excl. VAT)	Minimum Competition [1]
< £5,000	At the discretion of DoF
£5,000 - £25,000	3 Written quotations
£25,000 – OJEU threshold	4 Tenders
Above OJEU threshold	5 Tenders
Contracts above £1 million	In addition to the above, WG approval required [2]

[1] Subject to existence of suitable suppliers
[2] In accordance with requirements in SFI 11.6.3

Advice from Procurement Services must be sought for all requirements in excess of £5,000.

7.2 Delegation of Authority

In addition to the procurement thresholds, the Health Board Standing Orders (SOs) state that there should be a Scheme of Delegation, detailing the amounts that individuals have delegated authority for approving. Delegated authority relates to total contract value over the life of a contract or individual purchase value. Authorisers must not artificially split contract or invoice values to enable them to authorise higher total values.

The Scheme of Delegation is designed to enable the day-to-day business of the Health Board, to be carried out effectively, in a manner that secures achievement of the organisation's aims. The Scheme of Delegation is supported by the Authorised Signatory List (ASL), which sets out

comprehensive details of approval amounts and the financial codes against which individuals can authorise the ordering of goods and services. The application to become an authorised signatory can be found here.

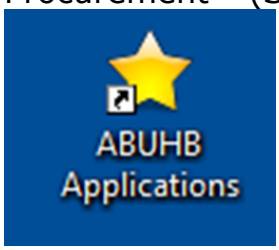
7.3 No Purchase Order No Payment

Each Welsh organisation has adopted a NO Purchase Order No Payment (No PO No Pay) policy. Under the policy, all goods and services must be supported by a prospective Aneurin Bevan Purchase Order (PO). Retrospective or confirmation orders should be avoided and only used if absolutely necessary. Purchase orders in ABUHB are used to ensure that all goods and services are duly authorised at the appropriate level within the organisation. POs set out ABUHBs terms of trade, ensure that the purchase to pay (P2P) process is efficient and that suppliers are paid within Welsh Government requirements.

All relevant suppliers have been contacted, stating the No PO No Pay approach. Invoices received within Accounts Payable (AP) not displaying an official purchase order number will be returned to the supplier unpaid with a request to provide an order number.

7.4 Purchasing Goods and Services

All purchases must be made through the Oracle System using Self Service Procurement (SSP) available on the ABUHB Applications page.



Access to Oracle SSP requires a completed Oracle User Form and attendance at a formal training session provided by NWSSP-PS. For enquiries please contact one of the following:

Internal number 01796 4131 (option 2)
External number 02920 904131 (option 2)
Email NWSSP_procurementservicedesk@wales.nhs.uk

Or visit the Procurement Intranet Page here for further information.

7.4.1 Good Procurement Practice – Tendering

If you are planning to purchase goods or services or renew a contract you must always contact your NWSSP-PS representative in the first instance. They will provide advice and guidance throughout the process. A list of contacts can be found here.

Things to be considered when planning your purchase or contract:

- You must adhere to the procurement thresholds as set out within this policy and obtain the required internal and/or Welsh Government authorisation.

- You must identify requirements and consider the complexity and risk of the intended purchase or contract.

- Competitive procurement processes can take between 2-8 weeks (after internal approval).

- Requirements that exceed OEJU thresholds can take up to 12 months to procure depending on complexity and risk of the goods or services required.

Identifying a requirement and planning the procurement is an important step and NWSSP-Procurement Services must be engaged at the earliest opportunity to provide guidance and support needed to ensure compliance is maintained.

NWSSP-Procurement Services, working with end users, will endeavour to maximise competition engaging with the market at earliest stages and design service requirements that are accessible to as many providers as possible.

7.4.2 Good Practice – Ordering Goods and Services

- All goods and services must be ordered through Oracle SSP (see guidance in section 7.4.4)
- Ensure that all requisitions contain sufficient information to prevent delay in authorisation.
- Contact and discuss any uncertainty or problem with the NWSSP-Procurement Services
- Refer to associated guidance where necessary (see section 8)
- Consult with the NSWWP-Procurement Services for estimates and quotations.

- Never place an order via the telephone, all goods and services must be supported by a prospective purchase order otherwise it will be delayed for payment.
- Never renew or extend a contract without advice from NWSSP-Procurement Services
- Contact the NWSSP-Procurement Services **before** considering undertaking product trials.

7.4.3 Good Practice – Receipting Goods

Goods purchased must be receipted in Oracle SSP to enable invoices to be matched and paid within Welsh Government requirements. All goods must be receipted in Oracle within 2 days of the delivery date.

Services, such as contracts, room rental, course bookings etc, must also be receipted in Oracle otherwise invoices will be put on hold and delayed for payment until the receipting process has been carried out in Oracle.

7.4.4 Guidance for Order and Receipting in Oracle

Comprehensive training guidance and videos with instructions for ordering and receipting goods and services in Oracle SSP etc. can be accessed by clicking here

8. Resources

There are a number of supporting documents and training resources which can be accessed by clicking the links below:

Standing Orders
Standing Financial Instructions
Scheme of Delegation
Application for Authorised Signatory
Approval of orders over £100k
Oracle training resources

9. Training

All new Oracle SSP requisitioners are provided with initial training before being allowed to access the Oracle system. Links to supporting training materials can be found above.

15. Audit

Procurement and the ordering of goods and services is subject to internal audit.

16. Review

This document should be reviewed in 3 years from publication.

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AUDIT, RISK & ASSURANCE COMMITTEE
PROGRAMME OF BUSINESS 2023/24

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

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

- fulfil its Terms of Reference as agreed by the Board (March 2023);
- seek assurance and provide scrutiny on behalf of the Board, in relation to the delivery of the key elements of the health boards internal and external audit, counter fraud and PPV arrangements (second and third lines of defence);
- seek assurance that governance, risk and assurance arrangements are in place and working well;
- seek assurance in relation to the preparation and audit of the Annual Accounts; and
- ensure compliance with key statutory, national, and best practice audit and assurance requirements and reporting arrangements.

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24					
			18th April 2023	May 23rd *Draft Accounts*	July 18th *Final Accounts*	12th Sept	28th Nov	8th Feb 2024
Preliminary Matters								
Attendance and Apologies	Standing Item	Chair	√	√	√	√	√	√
Declarations of Interest		All Members	√	√	√	√	√	√
Minutes of the Previous Meeting		Chair	√	√	√	√	√	√
Action Log and Matters Arising		Chair	√	√	√	√	√	√
Committee Requirements as set out in Standing Orders								
Development of Committee Annual Programme of Business 2023/24	Annually	Chair & Director of CG	√					
Review of Committee Programme of Business	Standing Item	Chair	√			√	√	√
Annual Review of Committee Terms of Reference 2023/24	Annually **(April)**	Chair & Director of CG	√					
Annual Review of Committee Effectiveness 2022/23	Annually **(September)**	Chair & Director of CG				√		
Committee Annual Report 2022/23	Annually **(April)**	Chair & Director of CG	√					
Corporate Governance, Risk & Assurance								
Receive assurance on implementation of the Governance Priorities set out within the IMTP 2022-25	Quarterly	Director of CG					√	
Review and report upon the adequacy of arrangements for declaring, registering and handling interests	Annually	Director of CG			√			√
Receive full report of all offers of gifts and hospitality as declared	Annually	Director of CG			√			√
Compliance with Ministerial Directions	Bi-Annually	Director of CG			√		√	
Compliance with Welsh Health Circulars (WHCs)	Bi-Annually	Director of CG			√		√	√
Review of Standing Orders, Standing Financial Instructions and Scheme of Delegation	Annually	Director of CG						√

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24					
			18th April 2023	May 23rd *Draft Accounts*	July 18th *Final Accounts*	12th Sept	28th Nov	8th Feb 2024
Audit Recommendations Tracking Report	Standing Item	Director of CG	√	√	√	√	√	√
Annual Review of Risk Management Strategy	Annually	Director of CG						√
Report on the Implementation of the Risk Management Strategy Realisation Plan	Bi-Annually	Director of CG	√				√	
Annual Review of the Board Assurance Framework Process	Annually	Director of CG	√					√
Committee Risk & Assurance Report	Standing Item	Director of CG	√	√	√	√	√	√
Financial Governance and Control								
Report of the use of Single Tender Action	Standing Item	Director of FPV	√			√	√	√
Report of Losses and Special Payments *(May report will be included in the Accounts)*	Bi-Annually	Director of FPV		√			√	
Reviewed and Updated Financial Control Procedures	As Required	Director of FPV				√		
Annual Report and Accounts								
To consider the approach and timelines for the Annual Report and Accounts	Annually	Director of FPV & Director of CG	√					
Review the Health Board's Annual Report (Overview & Performance Section) (Part 1)	Annually	Director of CG		√	√			
Review Draft/Final Accountability Report, including Annual Governance Statement (Part 2)	Annually	Director of CG		√	√			
Review Draft/Final Annual Accounts and Financial Statements (Part 3)	Annually	Director of FPV		√	√			
Audit Enquiries to those charged with Governance and Management	Annually	Director of FPV		√				
Audit Wales, Audit of Accounts (ISA 260) including Letter of Representation	Annually	External Audit			√			
Final Annual Accounts Memorandum	Annually	External Audit					√	
Receive the Annual Head of Internal Audit Opinion (including Specialised)	Annually	Internal Audit			√			
Agree a recommendation to the Board in respect of the audited annual report and accounts	Annually	Chair			√			
Anti-Fraud								
Review of the Counter Fraud, Bribery and Corruption Policy	3-Yearly (Feb 2026)	Director of FPV	-	-	-	-	-	-

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24					
			18th April 2023	May 23rd *Draft Accounts*	July 18th *Final Accounts*	12th Sept	28th Nov	8th Feb 2024
Receive the Counter Fraud Annual Report	Annually	Head of CF	√					√
Agree the Counter Fraud Annual Workplan	Annually	Head of CF	√					
Receive a Quarterly Report on Counter Fraud Activity	Quarterly	Head of CF			√		√	√
Agree the Counter Fraud Functional Standard Return Declaration	Annually	Head of CF			√			
Receive the Post Payment Verification Annual Report	Annually	PPV Manager (Amanda Legge)				√		
Agree the Post Payment Verification Annual Workplan	Annually	PPV Manager		√				
Receive a Mid-Year update in respect of Post-Payment Verification Activity	Annually	PPV Manager					√	
Clinical Audit								
Ratify the Clinical Audit Plan 2023 – 2024 to be overseen by the PQSO Committee	Annually	Medical Director			√			
Receive an Annual Report 2023 – 2024 on Clinical Audit Activity	Annually	Medical Director						√
Internal Audit (Including Specialised Audit) – NWSSP Audit & Assurance Services								
Agree the Internal Audit Annual Workplan	Annually	Head of Internal Audit		√				
Receive Internal Audit Progress Reports	Standing Item	Head of Internal Audit	√	√	√	√	√	√
Receive Internal Audit Review Reports, reviewing the adequacy of executive & management responses to any issues identified, ensuring that they are acted upon	As Scheduled within Annual Work plan	Head of Internal Audit Plan						
Review and approve Internal Audit terms of reference (charter) and the effectiveness of internal audit	Annually	Head of Internal Audit with Chair			√			
External Audit – Audit Wales								
Receive the External Audit Annual Audit Report	Annually	Audit Wales						√
Agree the External Audit Annual Plan	Annually	Audit Wales		√				
Receive the 2023 Structured Assessment	Annually	Audit Wales						√

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24					
			18th April 2023	May 23rd *Draft Accounts*	July 18th *Final Accounts*	12th Sept	28th Nov	8th Feb 2024
Receive External Audit Progress Report 2023-24	Standing Item	Audit Wales	√	√	√	√	√	√
Review of External Audit Reports including results & the adequacy of executive & management responses to any issues identified, ensuring that they are acted upon	As Scheduled within Annual Work plan	Audit Wales						
Consider any Audit Wales National Value for Money Examinations & Performance Reports	Ad-hoc	Audit Wales						
Audit, Risk and Assurance Committee Members to meet Independently with:								
External Audit Team	Bi-Annually	Chair	√					√
Internal Audit Team	Bi-Annually	Chair					√	
Local Counter Fraud Team	Bi-Annually	Chair				√		

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

KEY	
√	Received at the scheduled meeting
X	Not received / Deferred to future meeting
Received √	Received deferred Item
	Draft & Final Accounts

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	12 September 2023
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Audit Risk and Assurance Committee Self-Assessment
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 purpose of this report is to inform the Committee of the annual self-assessment process and to discuss the self-assessment template, which is appended to the report as Appendix 1.

Cefndir / Background

As part of the Health Board's statutory requirements, each Committee of the Board is required to conduct an annual self-evaluation of committee effectiveness. All Board Members are required to complete a self-assessment for each Committee on which they are a member, to determine its effectiveness and ability to carry out its responsibilities.

The outcome of the assessment will enable the Committee to identify areas of development and focus for the coming year, such as any training and development, as well as changes to processes and procedures.

Asesiad / Assessment

Traditionally, the self-assessment is completed at the end of every financial year to determine committee members' opinions on the effectiveness of the committee throughout the year; however, it has been agreed that the self-assessment process will be completed midway through the year, (October/November) on the basis, that this will inform the Committee Annual Report, Annual Accountability Report and Governance Statement. This will also inform the Board's overall evaluation of its effectiveness.

Following discussion, if the Committee considers the self-assessment template (appendix 1) is a useful tool, the template will be shared with members by the first week of October for a period of four weeks. Following this, the Corporate Governance Team will compile the responses into charts for the November Audit Committee's consideration and discussion.

The template will also serve as the foundation for developing the self-assessment checklist for the Board's other Committees, where applicable.

Argymhelliad / Recommendation

The Committee is asked to:

- **NOTE** the report,
- **CONSIDER** the self-assessment template for completion in order to inform areas of development for the forthcoming year, and;
- **AGREE** to the Committee undertaking the self-assessment as per the timescales set out.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The self-assessment of committee effectiveness ensures risk is appropriately monitored and managed.
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:	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:	None

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	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Choose an item.

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

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Audit, Risk and Assurance Committee Self-Assessment Checklist

1. Committee Processes:

Composition, Establishment, and Ways of Working

1 = Room for Improvement	2 = Meeting the Standards	3 = Excelling

	Area/Question	Rating			Comments	Suggested Improvement Actions
		1	2	3		
1	Does the Committee have written terms of reference and have they been approved by the Board?					
2	Are the terms of reference reviewed annually?					
3	The number of meetings held during the year is sufficient to allow the Committee to perform as effectively as possible?					
4	Has the Committee been quorate for each meeting this year?					
5	In terms of numbers, membership of the Committee is sufficient to discharge its responsibilities?					
6	Members who have recently joined the ARAC have been provided with induction training to help them understand their role and the organisation?					
7	The Committee is clear about its role in relationship to other Committees that play a role in relations to clinical governance quality and risk management?					

8	Committee members understand their responsibilities regarding identifying, declaring, and resolving conflicts of interest?			
9	The Committee uses assurance mapping to identify where assurance is required and identify any key gaps where no assurance is provided, or where the quality of the assurance is poor?			
10	The Committee has an established a plan of matters to be dealt with across the year?			
11	Does the Committee consider issues at the right time and in the right level of detail?			
12	The Committee ensure that the relevant executive director attends meetings to enable it to understand the reports and information it receives?			
13	Are the Committee's papers distributed in sufficient time for members to give them due consideration?			
14	The quality of the Committee's papers received allows Committee members to perform their roles effectively?			
15	Committee meetings are chaired effectively?			
16	The Committee chair allows debate to flow freely and does not assert his/her own view too strongly?			
17	The Committee environment enables people to express their views, doubts, and opinions?			

18	The Committee challenges management and other assurance providers to gain a clear understanding of their findings?			
19	Members hold their assurance providers (management) to account for late or missing assurance?			
20	Internal and External Audit contributes to the debate across the range of the agenda?			
21	Each agenda item is 'closed off' appropriately so that the Committee is clear on the conclusion; who is doing what, when and how and how it is being monitored?			
22	At the end of each meeting the Committee discuss the outcomes and reflect on decisions made and what worked well, not so well etc?			
23	Decisions and actions are implemented in line with the timescale set down?			
24	Are the outcomes of each meeting and any internal control issues reported to the next Board meeting?			
25	Does the Committee prepare an annual report on its work and performance for the Board?			
26	The results of the annual self-assessment are used to inform and influence succession planning and improve effectiveness.			
27	The self-assessment is objective and rigorous enough for meaningful conclusions to be drawn?			

2. Internal Control and Risk Management							
1 = Room for Improvement		**2 = Meeting the Standards**			**3 = Excelling**		
	Area/Question	**Rating**			**Comments**	**Suggested Improvement Actions**	
		1	**2**	**3**			
28	Has the Committee reviewed the effectiveness of the organisation's assurance framework?						
29	The Committee has an effective system for monitoring management's progress with recommendations from internal and external sources?						
30	Does the Committee receive and review the evidence required to demonstrate compliance with regulatory requirements – for example, as set by the Health Inspectorate Wales, Audit Wales, HSE etc?						

31	The Committee challenges management on whether there is a comprehensive process for identifying and evaluating risk, and for deciding what levels of risk are tolerable?			
32	The Committee critically challenges and reviews the adequacy and effectiveness of control processes in responding to risks?			
33	The Committee has a good understanding of how the organisation develops, operates, and monitors the system of internal control.			
34	When any significant failings or weaknesses in internal control arise, the Committee reviews management's analysis of the root cause and subsequent action plan.			

35	Has the Committee reviewed the accuracy of the draft annual governance statement?			

3. Annual Report and Accounts and Disclosure Statements

1 = Room for Improvement	2 = Meeting the Standards	3 = Excelling

	Area/Question	Rating			Comments	Suggested Improvement Actions
		1	2	3		
36	Does the Committee receive and review a draft of the organisation's annual report and accounts?					
37	**Does the Committee specifically review?**					
	a. Changes in accounting policies?					
	b. Changes in accounting practice due to changes in accounting standards?					
	c. Changes in estimation techniques?					
	d. Significant judgements made in preparing the accounts?					
	e. Significant adjustments resulting from the audit?					
	f. Explanations of any significant variances?					

38	Is a meeting of the Committee scheduled to discuss any proposed adjustments to the accounts and audit issues?			
39	Does the Committee ensure it receives explanations for any unadjusted errors in the accounts found by the external auditors?			

4. Internal Audit

1 = Room for Improvement | **2 = Meeting the Standards** | **3 = Excelling**

	Area/Question	Rating			Comments	Suggested Improvement Actions
		1	2	3		
40	Is there a formal 'internal audit charter' which includes terms of reference, defining internal audit's objectives and responsibilities?					
41	Does the Committee review and approve the internal audit plan and any changes to the plan?					
42	Is the Committee confident that the audit plan is derived from a clear risk assessment process?					
43	Does the Committee receive periodic progress reports from the Head of Internal Audit?					
44	Does the Committee effectively monitor the implementation of management actions arising from internal audit reports?					
45	Does the Head of Internal Audit have a right of access to the Committee and its chair at any time?					

46	Is the Committee confident that Internal Audit is free of any scope restrictions, or operational responsibilities?			
47	Has the Committee evaluated whether Internal Audit complies with the Public Sector Internal Audit Standards?			
48	Does the Committee receive and review the Head of Internal Audit's Annual Opinion Report?			
49	Does the Committee hold periodic private discussions with external auditors?			

5. External Audit

1 = Room for Improvement	2 = Meeting the Standards	3 = Excelling

	Area/Question	Rating			Comments	Suggested Improvement Actions
		1	2	3		
50	Do the external auditor's present their audit plan to the Committee for agreement and approval?					
51	Does the Committee review the external auditor's ISA 260 report (the report to those charged with governance)?					
52	Does the Committee review the external auditor's value for money conclusion?					

53	Does the Committee review the external auditor's opinion on the quality account when necessary?			
54	Does the Committee hold periodic private discussions with external auditors?			
55	Does the Committee require assurance from External Audit about its policies for ensuring independence?			
56	Has the Committee approved a policy to govern the value and nature of non-audit work carried out by the external auditors?			

6. Clinical Audit

1 = Room for Improvement	2 = Meeting the Standards	3 = Excelling

	Area/Question	Rating			Comments	Suggested Improvement Actions
		1	2	3		
57	If the Committee is NOT responsible for monitoring clinical audit, does it receive appropriate assurance from the relevant Committee?					
58	**If the Committee is responsible for monitoring clinical audit has it:**					

	a. Reviewed an annual clinical audit plan?			
	b. Received regular progress reports?			
	c. Monitored the implementation of management of actions?			
	d. Received a report over the quality assurance processes covered by clinical audit activity?			

7. Counter Fraud

1 = Room for Improvement	2 = Meeting the Standards	3 = Excelling

	Area/Question	Rating			Comments	Suggested Improvement Actions
		1	2	3		
59	Does the Committee review and approve the counter fraud work plans, and any changes to the plans?					

60	Is the Committee satisfied that the work plan is derived from an appropriate risk assessment and that coverage is adequate?			
61	Does the audit Committee receive periodic reports about counter fraud activity?			
62	Does the Committee effectively monitor the implementation of management actions arising from counter fraud reports?			
63	Do those working on counter fraud activity have a right of direct access to the Committee and its chair?			
64	Does the Committee receive and review an annual report on counter fraud activity?			
65	Does the Committee receive and discuss reports arising from quality inspections by NHSCFA?			
66	Does the Committee hold periodic private discussions with external auditors?			

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	12 September 2023
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:**	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Lucy Windsor, 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 presents the Audit, Risk, and Assurance Committee (referred to as the Committee throughout the report) with an overview of all identified internal and external audit recommendations and current implementation status as at 30th June 2023.

The paper also seeks to provide an update on recommendations that have progressed since the last reporting period, where a revised deadline has been proposed, recommendations that remain outstanding, and an overview of management action plans that have now been completed in their entirety.

Cefndir / Background

At its last meeting, the Committee agreed to transition to quarterly reporting if all longstanding (pre-date 2022/23 reporting year) Internal and External Audit Recommendations had either been completed or a proposed revised deadline with a robust action plan to complete recommendations had been provided.

Tables 1 and 2 overleaf summarise the status of all outstanding recommendations by year and priority rating. Table 1 lists all the long-standing (2017-2021) recommendations, while Table 2 lists the number of overdue recommendations from audits performed in the 2022/23 audit year.

The Executive Team has agreed to ensure that there are no long-overdue recommendations in the next iteration of the report that do not have revised deadlines.

Table 1

All Longstanding (pre-2022) Overdue Recommendations as at 30 June 2023					
Year	**Priority Rating of Recommendation**				**Total**
	Low	Medium	High	N/A	
2017	**-**	**-**	**4**	**-**	**4**
2018	**-**	**-**	**4**	**-**	**4**
2019	**-**	**-**	**1**	**-**	**1**
2020	**-**	**1**	**-**	**15**	**16**
2021	**8**	**30**	**5**	**7**	**50**
Total	**8**	**31**	**14**	**22**	**75**

Table 2

All Overdue Recommendations from 2022/23 financial year as at 30 June 2023					
Year	**Priority Rating of Recommendation**				**Total**
	Low	Medium	High	N/A	
2022	**23**	**58**	**10**	**4**	**95**

The combined total for both tables **(170)** was the number of recommendations that required an update against, this is broken down in the main body of the report.

The revised format for reporting recommendations that have passed their original and revised completion dates, as well as those that were closed during the previous reporting period, provides greater transparency and accountability about the status of recommendations, and allows the Committee to thoroughly scrutinise the information provided in order to obtain assurance of the implementation and progress of Internal and External Recommendations.

Asesiad / Assessment

Internal and External Audit Recommendation Tracking, 30 June 2023

Since the previous reporting period, 31 March 2023, work has been completed to update the master tracker to include all Internal and External Audit Recommendations up until the last Committee meeting on 18 July 2023.

The Committee has been provided with data regarding the status of all overdue and completed recommendations as at the 30 June 2023 for this iteration of the report.

Following the previous reporting period, which ended on 31 March 2023, several revised timeframes were agreed upon, leaving a residual position of **30** overdue internal and external

recommendations. A further **140** recommendations were triggered as overdue in Q1 (April – June). In total **170** updates against overdue recommendations were requested.

The position reported in Table 3 reflects updates received against all overdue recommendations up to 30 June 2023.

Table 3

Overview of Recommendation Activity for Quarter 1 Reporting Period												
Lead Director	**Chief Executive**	**Chief Operating Officer**	**Director of Corporate Governance**	**Director of Digital**	**Director of Finance and Procurement**	**Director of Nursing**	**Director of Public Health**	**Director of Strategy, Planning and partnerships**	**Director of Workforce and OD**	**Medical Director**	**Director of Therapies and Health Science.**	**Total**
IA Overdue	-	38	5	38	3	6	-	7	3	3	5	108
EA Overdue	-	0	-	2	-	1	-	-	2	-	-	5
Revised Deadline	-	17	5	-	-	4	-	1	3	-	4	34
Completed	1	19	5	9	7	-	-	14	2	-	-	57

NB: The revised number of deadline(s) requested are included in the overdue figures.

The position reported in this paper reflects the position as at 30 June 2023 in which there are **113 overdue** internal and external recommendations, of which, **34 of the 113** have been assigned a revised timescale for implementation for approval by the Committee and **57** have been **completed.**

If the committee approves the 34 revised deadlines the residual overdue position will be as follows:

- **75** Internal Recommendations
- **4** External Recommendations

The data in the summary tables (4-7) provide a breakdown of overdue and completed internal and external recommendations by the Lead Director.

Internal Audit

Table 4 summarises the Lead Director's position as of 30 June 2023, in relation to the **108** (33 of the 108 have revised deadlines) **overdue** internal audit recommendations. Appendix 1 contains all overdue Internal Recommendations that do not have a revised timeframe.

Table 4

Internal Audit Overdue Recommendations					
Director	**Priority Rating of Recommendation**				**Total**
	Low	Medium	High	N/A	
Chief Operating Officer	**11**	**25**	**2**	**0**	**38** (*17)
Director of Corporate Governance	**1**	**4**	**0**	**0**	**5** (*5)

Director of Digital	**4**	**22**	**2**	**10**	**38**
Director of Finance and Procurement	**0**	**1**	**0**	**2**	**3**
Director of Nursing	**2**	**2**	**2**	**0**	**6** (*3)
Director of Strategy, Planning and Partnerships	**1**	**6**	**0**	**0**	**7** (*1)
Director of Workforce and OD	**2**	**0**	**1**	**0**	**3** (*3)
Medical Director	**0**	**3**	**0**	**0**	**3**
Director of Therapies and Health Science	**0**	**2**	**3**	**0**	**5** (*4)
Total	**21**	**65**	**10**	**12**	**108**

**(X) Revised number of Deadline(s) requested.

The **33** internal audit recommendations with proposed revised timescales for implementation can be found at Appendix 2.

On the basis that the Committee endorses the **33** revised timeframes, **75** internal audit recommendations will remain **overdue** as at 30th June 2023.

Table 5 below summarises the position reported as at 30th June 2023 by the Lead Director, in respect of **completed** recommendations. **48** internal overdue recommendations have been completed in this reporting period. Further detail can be found at Appendix 3.

Table 5

Internal Audit Completed Recommendations					
Director	**Priority Rating of Recommendation**				**Total**
	Low	Medium	High	N/A	
Chief Operating Officer	**5**	**10**	**4**	**-**	**19**
Director of Corporate Governance	**-**	**-**	**-**	**2**	**2**
Director of Digital	**-**	**1**	**1**	**5**	**7**
Director of Finance and Procurement	**-**	**4**	**-**	**1**	**5**
Director of Strategy, Planning, and Partnerships.	**5**	**7**	**2**	**-**	**14**
Director of Workforce and OD	**1**	**-**	**-**	**-**	**1**
Total	**11**	**22**	**7**	**8**	**48**

External Audit

Table 6 below summarises the position as at 30th June 2023, in relation to the **6** (2 of the 6 have revised deadlines) **overdue** external audit recommendations. Appendix 4 contains all overdue Internal Recommendations that do not have a revised timeframe.

Table 6

External Audit Overdue Recommendations					
Director	**Priority Rating of Recommendation**				**Total**
	Low	Medium	High	N/A	
Director of Digital	**-**	**1**	**1**	**-**	**2**
Director of Nursing	**-**	**-**	**-**	**1**	**1** *(1)
Director of Workforce and OD	**-**	**-**	**1**	**1**	**2**
Total	**-**	**1**	**2**	**2**	**5**

*(X) Revised number of Deadline(s) requested.

The **1** external audit recommendations with proposed revised timescales for implementation can be found in Appendix 5.

On the basis that the Committee agrees to the **1** revised timeframe, **4** external audit recommendations will remain **overdue** as at 30th June 2023.

Table 7 below summarises the position reported as at 30th June 2023 by the Lead Director, in respect of **completed** recommendations. Further details can be found at Appendix 3.

Table 7

External Audit Completed Recommendations					
Director	**Priority Rating of Recommendation**				**Total**
	Low	Medium	High	N/A	
Chief Executive	**-**	**-**	**0**	**1**	**1**
Director Of Corporate Governance	**-**	**-**	**3**	**0**	**3**
Director of Finance and Procurement	**-**	**-**	**0**	**2**	**2**
Director of Workforce and OD	**-**	**-**	**0**	**1**	**1**
Total	**-**	**-**	**3**	**4**	**7**

Since this reporting period 30th June 2023, recommendations with deadlines in quarter 2 of the financial year 2023/24 would have become overdue. These will be updated in preparation for the next reporting cycle.

For information, attached as Appendix 6 is all recommendations Not Yet Due as at 30 June 2023.

Argymhelliad / Recommendation

The Audit, Risk & Assurance Committee is asked to:

- **NOTE** the position in respect of overdue audit recommendations.
- **NOTE** the position in respect of complete audit recommendations.
- **APPROVE** the revised timescales for the **33** Internal and **2** External Audit Recommendations.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Risks associated with overdue recommendations will be captured locally and escalated to the strategic risk register if necessary.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Integral to the delivery of the IMTP
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

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

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


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

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Priority	Recommen-dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Proposed Revised Deadline	Due	If closed and not complete please provide justification and	Progress of work underway	Reporting Date
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R1	R1 The governance framework for IM&T / digital should be clarified and where control over aspects of IM&T has devolved to departments, there should be a process for these to feed into the relevant Committee to ensure oversight. Underneath the Committee the steering group remit and membership should be defined.	Agreed. The Health Board is establishing a new governance framework. Currently Informatics is reporting to the Audit Committee, the first report is scheduled for 8thApril. A Health Board governance framework is in development for informatics including exec oversight, investment and delivery. The management of the global pandemic has disrupted the planning work by 12 months but this is now re initiated. Recommendations arescheduled to be presented to Exec TeamQ1 , and Board in Q2;	30/06/2021		Overdue		Aug-23: First HBOTs meeting was held in June 2023 chaired by Rani Dash, Director of Corporate Services. Work ongoing around the Governance Structure. May 2023 - The Governance Structure will be discussed at the SIRO meeting. The meeting will be attended by the new Digital Director who will finalise these arrangements when he takes up post. March 2023 - The inaugural meeting for the Office of the SIRO is in May. It will be attended by a representative from Templar to explain to the membership of the group the purpose and aims of the group. The TOR was given approval from the SIRO. January 2023 - - Training for office of the SIRO completed and update to be provided to Exec Team Dec 22. GAB will report and make escalations through this new office. GAB Board e3stablished with ToR drafted.providing GAGS with reporting mechanism and KPIs which will be escalated to the OSIRO where required. SIRO training has been completed and Rani Mallison to undertake this role. August 2022 - First meeting of Governance and Assurance Board held 27/7/2022 and will report into HBOTS and DDOB. SIRO identified and training dates being organised. June 2022 -: ToR revised for the Governance and Assurance Board to include IG and Cyber reporting now through the GAGS and to be noted at DDOB 12/7/2022 with first meeting of GAB scheduled for 27/7/2022 and reporting into HBOTS and DDOB. March 2022 - Governance & Assurance Board ToR in draft and the role of the Governance& Assurance Groups	30/06/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R4	R4 The risk identification process should be formally linked to the issue / event / problem management process in order to ensure that underlying risks are identified.	A review of risk management processes has commenced. The Health Board has appointed a Chief Nursing Information Officer/Clinical Safety Officer who will lead the project to align risk management processes from Programmes, design, Service Delivery, Health Records and Information Governance and Cyber Security to inform the new governance structure.	31/12/2021		Overdue		Aug-23: Risk management framework currently being reviewed by the new Director of Digital. May 2023 - Department risk management approaches are developing aligned to the corporate framework. A single risk register has been developed and is being rolled out, supported by internal risk management training/handholding. Once approaches are signed off, an informatics wide framework will be developed with new Digital Director. March 2023 - Clinical Assurance Process and Strategy is now approved and in place; Informatics Risk Management Approach under development January 2023 - Domains aligning risk registers with the Corporate template and to publish so that there is visibility of the entire Informatics Risk to be held by the PMO. The first domain is completed (Programmes) SPD, Service Delivery, ICT Health Records and IG to follow. Sept 2022 - Awaiting the Octboer DDOB for formal sign off. Aug 2022 - ADI's have signed off the Clinical Assurance process however the DDOB meeting to approve was cancelled therefore moved to next meeting 18/10/2022 June 2022 - Final Sign off requested from ADI's to present via CCIO report to DDOB on 12/7/2022. May 2022 -•Training has been provided to several members of the directorate to support the management of risks within programmes and projects. Engagement with the HB overarching risk management functions continues to assess the impact of the introduction of the	30/06/2023

Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R5	R5 The Health Board should ensure greater links with divisions and the Informatics Directorate. The Informatics Directorate should be involved in the decision making process for all IM&T items.	Accepted. The CDO will present the recommended Target Operating Model to the HB which will include governance over Informatics as a Division and also departmental systems. Part of the framework will include decisions to procure and assurance processes not only for informatics division but informatics services owned outside. Part of adoption will help appraise strategic options in how the HB wishes to take this forward. Part of the SIRO objectives will set out the responsibilities for devolved asset owners and a performance management framework to identify risk and provide oversight. There is likely to be a resource impact in achieving this which will be subject to a business case.	31/03/2021		Overdue		Aug-23: New governance group is under development to provide strategic oversight of digital initiatives, New Digital Service Request process is currently being finalised alongside a new Financial Control Procedure to provide governance and assurance over digital spend and initiatives. Business Partnership arrangements between Digital and the Divisions / Corporate Services is being planned. May 2023 - No additional TOF posts to be created pending new Director of Digital review March 2023 -Director of Digital will be reviewing the Target Operating Model once in post January 2023 - Paper has been submitted to CEO and is under consideration. September 2022 - The proposal for TOF structures will be submitted October 22 with note at DDOB. August 2022 - Governance and Assurance Groups have commenced and include governance around procurement of departmental systems June 2022 - financial planning has been completed, CDO to meet with Executive Director NP on next steps July 22 March 2022 - Resource requirements have been identified as part of the Target Operating Framework, but are yet to be agreed. The aim is to resolve by end of Q1/23 November 2021 - The Templar Report has identified the resource requirements to achieve this strategic objective and as part of their engagement will ensure that this is progressed and a performance management framework	30/06/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R6	R6 Consideration should be given to the placement of all informatics provision and support across the Health Board. As part of this the current partially decentralised model should be re-assessed in terms of its suitability for the modern use of technology.	Accepted. Following the exec review of the Target Operating Framework and overarching governance will appraise the hybrid environment of departmental asset ownership, responsibility, risk management. As the report sets out this is a largely historical and organic model which will be complex to resolve in itself. A risk based approach will be adopted andan options paper will be developed forconsideration by the Board.	31/12/2022		Overdue		Aug-23: The new Director of Digital is currently reviewing the TOF and will present findings and an action plan for the consideration by the Executive Committee in October 2023 November 2021 - This is pending the TOF being funded and requires a full risk assessment to be conducted once the business analysis has been completed.	30/06/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R7	R7 A review of the current strategic position of the Health Board in relation to its digital provision and maturity across all domains should be undertaken.	Partially accepted. The Health Board commissioned a review of the Health Boards capacity and capability to deliver the strategy with recommendations for the Board to consider. This was scheduled for Q1 2020/21 but supporting the Health Board through the pandemic became the priority. Whilst this was not a self assessment against a maturity model as in NHS England or HIMMS it provides a comprehensive framework. The report also makes recommendations about the principle of "Once for ABUHB" which if accepted will lead to a baselining of assets, processes and convention outside of the current Informatics Directorate footprint. The recommendations from the planning of the new operating framework are planned to be delivered to Exec Team Q1 and Board Q2 2021.	30/09/2021		Overdue		Aug-23: HIMSS report has been discussed at Directors of Digital and the learning is forming part of further planning and strategic discussions at a national level. May 2023 - HIMSS gap assessment site visit completed 4/5/23. Local report due 11/5/23. National report to be shared and discussed with Digital Directors in due course March 2023 - HIMSS Online survey complete and arrangements for on site visit underway January 2023 - Currently undertaking a HIMSS assessment as part of a national benchmarking exercise. September 2022 - Next steps have been agreed and a paper is drafted to be submitted in Oct 22. August 2022 - An update on progress aginst the Digital Strategy was presented to the Health Board Chair and Exec Team in July 2022. A Digital Delivery Oversight Board (DDOB) has been established to review progress, support prioritisation and give executive oversight and direction to the informatics teams. JunE 2022 - financial planning has been completed, CDO to meet with Executive Director NP on next steps July 22 November 2021-: A paper is being drafted for Digital Delivery Oversight Board scheduled in Jan 22 to meet the recommendations of the report with associated costs.	30/06/2023

Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R8	R8 An assessment of the changes needed to implement the Digital Strategy should be undertaken, and the benefits of the changes articulated, along with the consequences of no change. The Health Board should develop a single roadmap to help deliver the Digital Strategy.	As part of the review Informatics has accepted the need for P3O Portfolio management. This work is ongoing and with an initial focus to core Informatics Division activity but provides a framework for Health Board oversight and transparency. The portfolio approach will extend subject to Board approval to all information assets in a planned programme of work. This forms part of the recommendations to Execs in Q1 2021.	30/06/2021		Overdue		Aug-23: Progress being made on the portfolio register to surface all digital work including new service requests and ICT projects. Resource & capacity modelling being developed along with business change tools to support service readiness for change. May 2023 - Benefits audit carried out and substantial assurance awarded. Funding to fully establish the PMO not yet secured however a portfolio view of all digital service requests and trnasofmration programmes has been developed along with a prioritisation and optimisation framework. DDOB has been stood down temporarily so prioritisation is done on an ad hoc basis with members of the exec team. Mar 23: Funding required for Head of PMO however, digital Portfolio manager recruitment underway in Programmes and benefits audit completed with substantial assurance. January 2023 - Awaiting funding for Head of PMO. Benefits management audit underway in programmes. September 2022 This is part of the TOF paper submission Oct 22. August 2022 - Funding requested to progress Head of PMO to further support the portfolio development and implementation of the Digital Strategy. Report on the progress against the strategy shared with Board in July. Further update on benefits required for Nov/Dec audit committee. June 2022 - Portfolio dashboard under development and quarterly portfolio review & update meeting scheduled. Head of PMO included in TOF funding requirements.	30/06/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R9	R9 A network of champions across the organisation should be established. The Digital Strategy should be re-issued alongside the roadmap. This should form the basis for engaging the network of champions to drive the Strategy forward.	Accepted-The Channel 3 report also identified a need for more emphasis on Clinical Leadership, Design and Business Partnering. This is subject to additional investment although recently the appointment of a full time CNIO/CSO has been a significant step forward. Outwith the Directorate recommendations will be presented to Execs on overarching exec level oversight which is intended to both strengthen accountability but also to ensure Informatics capacity is used to best effect. Benefits realisation training has commenced in Informatics and will form part of reporting. It is in principle agreed that the Health Board adopts a single methodology and framework that should be co produced to manage all priority investments.	30/09/2021		Overdue		Aug-23: New Digital Service Request process, business partnering and new governance group is under development May 2023 - A divisional engagement model has been agreed for managing new service request and work in progress activities. A CSS meeting has been established. Urgent care to be established next and roll out to follow as resources allow. March 2023 - Director of Digital has been appointed and a review of the Digital Delivery Oversight Board will take place once they are in post January 2023 - Funded CNIO and Nursing Informatics lead. First Divisional meeting scheduled for December and await the outcome of the financial bid for the TOF September 2022 - Informatics have fully funded the Nursing Informatics Post and an increase in allocation for clinical leadership. The TOF paper being submitted in October 22 addresses the immidiate priorities for more effective engagement with Informatics in the HB. August 2022 - WNCR rollout plans include a nurse on each ward being champions for digital systems and GAG's promoting the need for diivisional champions to be identified by the SIAO's. June 2022 -: agreement of co-funding Informatics and Nursing, subject to financial strategy for TOF implementation; a review of stakeholder assets to be undertakent May 2022 - cost model submitted, seeking to deliver strategy end of Q1/23	30/06/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R13	R13 Critical assets should be identified within the asset and configuration management systems.	Agreed. This in part is due to the devolved nature of informatics.The first step will be presenting the new operating framework's overarching governance recommendations will provide oversight. A strategy, policy and resultant business case will be developed following the Health Board adoption of the reviews recommendations.	31/12/2021		Overdue		Aug 2023: Awaiting next HBOTS meeting. May 2023 - work to commence shortly under SIRO March 2023 - Part of work programme that will be commencing from May under Rani January 2023 - Part of the HBOTS work programme to be established wiith SIAOs September 2022 - Paper is drafted and will be submitted October 22. August 2022 - Pending financial strategy andTOF implementation June 2022 - subject to financial strategy for TOF implementation November 2021 - This is dependent on the TOF being implemented and the business analysis to be conducted	30/06/2023

Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R14	R14 The asset and configuration management processes developed within the Informatics Directorate should be adopted as Health Board wide documents and departments with devolved control required to comply with the requirements.	Accepted. The HB governance, policy and processes will be reviewed as part of the SIROs objectives with resultant recommendations to Board. Informatics will need to review internal processes and capacity to ensure it can scale to meet the challenge.	31/12/2021		Overdue		Aug 2023: Awaiting next HBOTS meeting. May 2023 - work to commence shortly under SIRO March 2023 - Part of work programme that will be commencing from May under Rani January 2023 - Part of Cyber Resilience Programme- SIAOs in the process of being identified by new SIRO supported by Informatics- SIAOs will be trained and each will be accountable to identify assets within each division and directorate. September 2022 - SIRO training completed and new plan to be agreed in first Office of SIRO meeting. August 2022 - SIRO training scheduled in September and letters of delegatioN to be issued thereafter to the identified Senior Information Asset Owners June 2022 - Cyber Resilience programme commenced May 2022 - contract awarded to consultancy Mar 2022 to implement recommendations - Office of the SIRO / delegated letters of authority to all information asset owners November 2021 - A report commissioned by the Health Board has been presented at the Digital Delivery Oversight Board and accepted. A proposal on next steps will be presented with associated costs to Executive Team	30/06/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R14	R11 The Informatics Directorate should develop an overarching workforce plan that sets out the resource gaps together with the skills gaps and how they are to be resolved. The plan should consider apprenticeships, coordinated departmental development and partnerships in order to maximise the use of limited financial resource.	Planning despite COVID continued on the Operating Framework based on existing mandate and footprint of Informatics portfolio. This addresses key areas of competencies and capacity. This has been supported activity with HR & OD and Finance. The new structure proposal reflects the Digital Strategy and Operating Framework but will require scrutiny challenge and approval.	30/09/2021		Overdue		Aug-23: ABUHB now represented at Digital Workforce Capability meeting. Work to align JD's with skills and competencies is progressing well and we have a comprehensive register of training opportunities and requests. January 2023 - Working through SOP for training and prioritisation of requests to be agreed. Skills profiles being matched with JD's and engage on national task and fiish group to provide benchmarking September 2022 - The DIrectorate now has a small but dedicated budget for training and development to support the PADR and workforce planning agenda. August 2022 - Register of training opportunities, expressions of interest forms to be completed and assessed by senior manager with identification of funding available if applicable. June 2022 - Limited training budget identified and PMO have list of training opportunities available to staff. Agreement on Process and prioritisation of training to be undertaken in the next quarter March 2022 - prioritised and phased cost model submitted November 2021 - The Informatics service is engaging iwith Health Education and Improvement Wales to further develop Health Informatics apprenticeship pathways from entry level. The service is actively engaged with HR &OD, Finance colleages to ensure the best route to recruitment and retention of staff. The TOF provides the resoure/skills gap that currently exists and the	30/06/2023
Internal	2021.00	Clinical Futures - Transport, March 2021	Reasonable	Chief Operating Officer	Low	R3	R3 We recommend that the Health Board ensure that for each of the MHLD projects that benefit realisation planning is extended to cover:•the collection of baseline data;•targets or success measures with which to compare what is actually achieved;•the measurement and recording of the benefit metrics;•responsible managers; and•the oversight body of the benefits, to ensure these are achieved.	Agreed. We acknowledge that a robust benefits realisation plan needs to be developed and we are looking to commission external support to assist with this process for the SISU Programme. A tender is currently developing a tender to progress this element of the project. This is part of the OBC development and will be completed before submitted to the Board for approval.WPWS –to review benefits realisation plans for supporting projects	30/09/2021		Overdue		Aug 2023: New phone systems to be implemented to enable capturing KPIs. Nov 2022: There has been a delay to gaining external support for the benefits realisation plan due to Omicron variant service impact. However Internal benefits work has been undertaken and measurable benefits developed for each service area within SISU. The OBC including benefits realisation is planned to be completed and submitted to the September Board. Benefits realisation plans and measures are being built in to all workstreams of WPWS work. Sanctuary project is being formally evaluated externally. Other alternative to admission workstreams now collecting triangulated service user experience measuresas well as baseline measures. Nov 2022 - commissioned an external organisation (arcus) to undertake the benefits realisation work on HB behalf in relation to the OBC.	30/06/2023
Internal	2021.00	Clinical Futures - Transport, March 2021	Reasonable	Chief Operating officer	Medium	R2	R2 The Flow Centre Team should:•review the current completion of the screening / transfer process documentation and establish a standard expectation of completeness;•provide refresher training to the team members, if required;•undertake periodic checks of all staff members, to ensure consistency and feedback any positive performances and improvements to individuals. This should also link into the PADR process;remind staff that the WAST incident number should be recorded to provide traceability; and•all screening questions shouldbe uploaded to CWS, where required.	Agreed. We will do this by:•implementing a staff review process, including an audit of referral information (this aspect is already implemented);•monitoringstaff performancee.g. logging in times and periodically listening to callsand to feedback onperformance;•addressing any training needs that ariseand link this to one-to-ones and the PADR process;•continuingto emphasise the importance of accurately recordinginformation e.g. WAST incident numbers, GP surgery etc.;•providingregular refresher training;and•hosting team meetings to share case studies / best practiceand address any issues / concerns that arise.	30/09/2021		Overdue		Aug 2023: Band 6 nurse compentency booklet has been implemented and Call audits template has been created. Due to LTS the regular auditing has bee delayed. The band 3 auditing is ongoing but due to the roll out of training of the new cohorts has meant the 10% auditing of all band 3 calls target has not always been achived. Plan to roll this out to all band 6's to cover June 2023 - work has commenced on QPS and call audit	30/06/2023

Internal	2021.00	Mental Health & Learning Disabilities Divisional Review, June 2021	Reasonable	Chief Operating officer	Low	R3	R3 We recommend that the Flow Centre Team produce and monitor regular performance information over key risks within the process. For example, call waiting times.As this process is already underway, the Team should continue to identify other key performance indicators.This information should also link into individual performance within the Team, for training and improvement.	Agreed. We will:•clarify the audience and reporting requirements;•monitor performance information / KPIs on a regular basis;•identify the top five indicators;•develop a reporting dashboard;and•further refine performance reporting.	30/09/2021		Overdue		June 2023 - Remodelling of service and introduction of APP to FC so KPI to develop in line with new modelling	30/06/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R2	R2.1 The Health Board should: • Consider undertaking risk management training for key areas, whilst awaiting the implementation of the risk management module within DatixCloudIQ. • Develop a plan to deploy risk management training, to commence once the full implementation of DatixCloudIQ has been completed.	As part of the strategy realisation plan, the Health Board will develop an in-house training package aimed at the three levels outlined within the Strategy (operational, management and Board level). This will be made available to relevant staff during May/June 2022. Further National development work will resume once the RLDatix risk management module has been finalised and bespoke training programmes can then be developed.	30/06/2022		Overdue		Aug 2023: The RadIS team have been working closely with ABUHB in order to upgrade teh at risk server and we have currently got a pencilled in date of the 16/09/2023 if this slips it will likely be November time.	30/06/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R6	R6 a.Radiology have requested CWS to work with WCP for fully electronic requesting. b.Staff have SOP's and checks when putting forms on however human errors do occur without fully electronic requesting.	Since this audit,this has now been altered and note it wasonlyone user with this many attempts all Administrators now have 5 attempts.	01/03/2022		Overdue			30/06/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	High	R3	R3 Whilst we understand the Health Board isin the process of planning to upgrade to the 2016 version we highly recommend that the Health Board expeditesthe upgrade.	This upgrade took place on 14thNovember however only application server was upgraded. DHCW and ABUHB are working closely to plan the rest of the upgrade. However DHCW will not touch the RadIS local database which stores all of our crystal reports and letters. This is a risk and we havegone to our server team internally to plan anbackupsolutionfor the RadIS local database.	30/04/2022		Overdue		OFWCMS risk management model delayed nationally. Expected April 2023 for implementation and training/awareness to commence.	30/06/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R8	R8 The Health Boardshould request that this logging function be developed.The Health Board shouldconsider feeding WRIS events into the SIEM.	The health board have raised this at DHCW CAB along with other health boards. This is with DHCW to develop it is not in any Live RadIS version currently.	31/03/2022		Overdue		Currently with DHCW to develop,	30/06/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R9	R9 A formal disaster recovery plan for WRIS should be developed.	The Disaster recovery plan is to fail over to a mirrored system however, since the upgrade this needs to be re-visited and formally set out. ABUHB have a VMware environment where this is hosted.The Radiology departments have disaster recovery by using emergency packs in each department and a policy that explains how to use these emergency packs in a Radis downtime scenario.	30/04/2022		Overdue		Aug 2023: The BC plans in radiology are quite extensive and well practiced	30/06/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R10	R10 The WRIS backups should be subject to regular testing / restore to ensurevalidity.	A request to ensure that a process for regular testing of the back up to ensure their validity will be made.	30/04/2022		Overdue			30/06/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R1	R1 The Health Board should: • Provide guidance detailing how risks should be recorded and monitored at different levels within the organisation. • Ensure each risk entry is fully recorded in a standard format.	3.1 This recommendation forms part of the Risk Management Strategy realisation plan. The Health Board training programme will provide material and literature to help support staff to populate Datix and risk registers appropriately and consistently ensuring alignment with best practice. The provision of in-house training will be made available to staff by May/June 2022.	01/03/2022		Overdue			30/06/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R4	R4 The Health Board should seek clarity over what maintenance tasks are expected and establish a process to ensure that these are completed.	There is a backupregimen in place, and DHCW has been notified of how this works.The point will be raised and the next WRIS SMB, and a request made for clarity over the expected database maintenance tasks and the frequency of these.	31/03/2022		Overdue		A database that the alerts and notifications is on is not supported by RadIS.	30/06/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R5	R5 a.The Board should investigate an electronic solution to uploading requestsinto WRIS.b.The Board should introduce a completeness check to ensure that all requestsreceived have been entered into WRIS.	a.Radiology have requested CWS to work with WCP for fully electronic requesting. b.Staff have SOP's and checks when putting forms on however human errors do occur without fully electronic requesting.	31/03/2022		Overdue		Aug 2023: The UAT has been passed and this is currently being looked at by informatics	30/06/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R7	R7 The success of the use of the leavers list should be monitored to ensure that it works as anticipated and that all leaver accounts are removed on a timely basis.	We monitor this as much possible in Radiology. We have recently started receiving consultant leaver'slists from the Health Board and action these also.The success of the process will be tracked and evaluated to ensure it is working.	30/04/2022		Overdue		Aug 2023: Any leavers we will make inactive unless access is required for global imaging within PACS or cross boundry electronic requesting if they are still working within the Welsh NHS. We are still dependant on this list being provided.	30/06/2023
Internal	2021.15	Falls Managment	Reasonable	Director of Therapies and Health Science	Medium	R2	R2. The falls investigation and Datix recording process should reference the MFRA and confirm its completion in relation to the fall event. A fall should not be identified as 'unexpected' if a MFRA had not been completed, when it should have been (e.g. over the age of 65 years).	An ongoing audit process will be established aligned to evaluating the completion of DATIX incidents and the associated completion of the MFRA and will be included as an element of an audit cycle Due consideration will need to be given to the format of the incident reporting criteria within the new system.	30/09/2022		Overdue		Nov 2022 Work has been undertaken to look at the opportunities to use the falls focus review held within the DATIX system . This would further support the incident reporting process.	30/06/2023

Internal	2021.20	Medicines Managment	Reasonable	Medical Director	Medium	R2	R2.1 Management should review the Policy for the Management of Controlled Drugs and update where required.	The CD Policy is due for review during 2022/23. As in previous reviews a working group with representatives from Pharmacy and nursing will be set up to update the policy. A number of sections and standard operating procedures will be updated to make the policy more relevant and practical. This will support compliance with the policy. Controlled drug keys being held on their own may have been best practice. However, this may not be convenient on the wards. This could be removed in the updated version.The use of red pen on the wards is to make stock checks morevisible. The practicality of this will be reviewed.Keeping patients own CDs on a separate shelf may not always be possible. However, they should be clearly differentiated from ward stock.The policy will also include a description of the audit framework that will provide assurance the policy is being followed.	31/03/2023		Overdue		Update Aug 2023: The review date of the current policy is November 2023. Progress to review and update it was delayed to ensure compliance with the Welsh Government notification to ensure HB compliance with new Home Office licensing requirements for the Management of Controlled Drugs (this was issued late February 2023). Priority was given to the clinical areas where these licenses are required and to support the application process (ABSDAS services and community dental clinics). The new Home Office licensing arrangements will be included in the Management of Controlled Drugs Policy. The requirements within the Controlled Drugs Policy review identified several aspects that needed to be updated to reflect the changes in working practices. The revised operational procedures are being implemented prior to introduction of the new policy and are expected to be completed by the end August 2023. A revised Management of Controlled Drugs Policy has been drafted and is being reviewed across the Divisions and will provided to the Clinical Standards and Policy Group in November 2023 for approval.	30/06/2023
Internal	2021.20	Medicines Managment	Reasonable	Medical Director	Medium	R2	R2.2 Once the Policy for the Management of Controlled Drugs is updated, the Health Board should undertake periodic reviews to ensure wards are adhering to the updated Policyand confirm the areas of non-compliance identified as part of this review have been rectified.	The stand operating procedure for pharmacy 6 month stock check on the wards is being updated by a Principal Pharmacy Technician. This will include updating the way reconciliation checks confirmation are documented to ensure compliance.The policy can include the need for periodic audits to review use of the policy and confirm areas of non compliance have been rectified.	31/03/2023		Overdue		Update Aug 2023: The Pharmacy SOP for 6-monthly stock checks has been updated and is in place. A schedule of the checks is in place for all Acute Pharmacy sites. The new SOP is being used to undertake audits at RGH and NHH and these are due to be completed in September 2023. The checks will highlight to ward staff and the responsible Pharmacist where ward non-compliance is evident and needs to be addressed. The requirement forms part of the revised Management	30/06/2023
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Medium	R3	R3 Management should ensure that an Improvement Action Plan is developed promptly in order to avoid delays in implementation.	NIS Improvement Plan is already being developed by the Cyber Team. Thecompleted plan willbe presented for management review and sign off. Currently ABUHB are still awaiting the publication ofCAF Based Cyber Risk Register for the Health Board these risks identified by CRU following the CAF assessment may include remediations that will be incorporated into the Improvement Plan currently being developed.	31/07/2022		Overdue		Aug 2023: Awaiting next HBOTS meeting. May 23: work to commence shortly under SIRO Mar 23: Cyber continues to maintain the NIS Risk Register and Action plan against operational risks. Corporate level Cyber risks will transfer to HBOTS once this is fully erstablished Jan 23: Cyber continues to maintain the NIS Risk Register and Action plan. CRU are currently reviewing all risk registers submitted with a view to finding and reporting common risks to Welsh Government . This may result in a common approach for remediation being adpoted for all Boards.Cyber will await results and support any required actions to be taken as directed by CRU Sept 22: The completed and updated register is submitted. Aug 22: The ABUHB NIS remedial Action Plan has been used to support a CRU led workshop and support the remediation of risk identified on the CRU created ABUHB NIS Risk Register. Work is ongoing with internal stakeholders to complete a review of the ABUHB NIS Risk Register The completed register will be submitted to CRU during September 2022"	30/06/2023
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Low	R1	R1 For future iterations of the CAF there should be greater involvement of the system owners in the review of the responses	ABUHB will ensure that in future iterations of the CAF there is greater involvement of System Owners	31/12/2022		Overdue			30/06/2023
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Medium	R2	R2 Management should ensure that records of discussions and information provided to and from the CRU are captured for future annual self-assessments	Management will ensure that during any future self-assessments records of discussions and informationsupplied to the CRU will be captured and available for internal or external review	31/12/2022		Overdue			30/06/2023
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Medium	R4	R4 The costs associated with the improvement actions should be assessed and reported to a relevant committee to enable awareness of the full picture and prioritisation of actions and funding.	The NIS Improvement Plan will be submitted through the relevant governance committee for senior Management review and sign off. Prioritisation of remedial actions and related costs will be assessed through ABUHB formal risk governance structureand relevant committees. Note ABUHB are currently implementing the recommendations of the Templar consultancy report which will create the Office of the SIRO and create a new governance frameworkto support Risk Management within the Health Board.	30/09/2022		Overdue		AUG 2023: Awaiting next HBOTS meeting. May 23: work to commence shortly under SIRO Mar 23: Part of work programme that will be commencing from May under Rani Jan 23: Office of he SIRO has been established, implementation of supporting governance and structures are in progress allowing costs to be fully assessed and actions prioritised. Aug 22: The creation of the TOM and creation of the HBOTS is ongoing This will provide the risk management framework to allow costs associated to improvements to	30/06/2023
Internal	2021.24	Flow Centre	Reasonable	Chief Operating Officer	Medium	R1	R1.1 The Flow Centre Team should ensure that the reason for an aborted transfers should be adequately recorded.	The Flow Centre Team have performed regular audits throughout the year and learning outcomes identified. This recommendation features on our regular 1:1s with individuals, staff weekly updates and will be a focus over the next fewmonths in line with this audits recommendation.Assurance is given via the Operations Structure and Urgent Care Divisional meetings with a monthly frequency and contain a feedback loop to ensure learning is disseminated to the teams.Flow Navigator audit tool to be created. Key area of focus for our Flow Navigator Auditor over the next 2 months	31/07/2022		Overdue		Mar 23 •We have seen a marked improvement with regards to documentation – noted through auding. •We have a full time Senior Flow Navigator who is responsible for auditing to help with this aim •A Flow Navigator & Flow Nurse Audit Tool has been created, in regular use and had provided key themes for service improvement.	30/06/2023

Internal	2021.24	Flow Centre	Reasonable	Chief Operating Officer	Medium	R1	R1.2 The Flow Centre Team should ensure that the reason for an aborted transfers should be adequately recorded.	This audit has highlighted a key learning outcome regarding the process followed when closing calls on the system and the loophole associated with the system used for recording the referral (Nugensis).Learning identified and training provided to staff Key area of focus for our Flow Navigator Auditor over the next 3 months	31/07/2022		Overdue		Mar 23•A reduction has been noted •This remains a key area of audit	30/06/2023
Internal	2021.24	Flow Centre	Reasonable	Chief Operating Officer	Low	R2	R2 The Flow Centre Team should establish the required level of information to be documented on the Transfer Form for each patient screenedand all forms should be uploaded onto CWS.	In the past 3 months an internal audit performed by the department highlighted further evidence of this practice and an action plan has been implemented to improve this area of practice.Clinical audit tool to be created. Initial audit to be completed –5% of Flow Nurse workload. Learning identified and training provided to staff	30/09/2022		Overdue		Mar 23 A Flow Navigator & Flow Nurse Audit Tool has been created, in regular use and had provided key themes for service improvement.	30/06/2023
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Medium	R5	R5 A formal reporting route for cyber security should be established to ensure that senior staff are aware of the position relating to cyber security.5.2The risk description should be reviewed, with inclusion of the potential financial penalties relating to noncompliancewith NIS.	ABUHB are adopting recommendations of the Templar Report that will establish a formal risk governance and committee structure within the Health Board which will support Cyber Security Risk Reporting.5.2As part of the improvements suggested by Templar a new Cyber Risk Register will be developed. As part of development process account will be taken to include the financial penalties associated with noncompliance to NIS regulatory requirements into the assessment methodology and reporting.	30/09/2022		Overdue		Aug 2023: Awaiting next HBOTS meeting. May 23: work to commence shortly under SIRO Mar 23: Part of work programme that will be commencing from May under Rani Jan 23: Regular cyber reporting is in place, currently this runs through Digital Delivery Oversight Board and to execs. This will change to HBOTS/SIRO once fully established Sept 22. The reporting route is being established following the appointment of the new SIRO. Aug 22: Work is ongoing to implement the TOM and supporting Risk management framework, A governance and Assurance Committee has been established this will report IG and Cyber risks identified at the GAGS through to the HBOTS . This will be supported by a corporate risk management methodology. The assessment methodology and risk scoring will capture the costs of non compliance to NIS and subsequent financial penalties that could be	30/06/2023
Internal	2021.26	Facilities - Care After Death	Reasonable	Chief Operating Officer	Low	R4	R4 The Care after Death Team should:•develop call cascade lists to identify staff contact details in advance;•identify additional scenarios that may arise and detail action plans to overcome them;•test a range of continuity events regularly (at least once a year); and•identify fridge / freezer capacity plans that could be utilised in across different sites, in the event of unavailability.	The CaD Team accept this recommendation in full.	30/09/2022		Overdue		Update August 2023 - fridge/freezer capactiy available on the database and space can be identified in the event of unavailabitliy. Mar 23 Being developed by CAD Manager. 24/03/2023 CAD Team have been sited within CSS Division since November 2022. Due to temporarily return to E&F in April; Facilities Manager to work with team to completion during Q1 of 2023/24.	30/06/2023
Internal	2022.01	CYP Continuing Care	Reasonable	Chief Operating Officer	Medium	R2	Incorporate the use ofthe recently developed All Wales CCN Senior Nurse forum KPIs for CCNS within the performance monitoring process.Regular monitoring of the performance report within the CCNS with annual (minimum) reporting to the Division.	Medium1)RL Datix to be utilised further to capture compliments as an initial step to provide more balance. 2)Key Performance Indicators for the Children's Community Nursing Service is being looked at within the All Wales Forum. Once finalised, these will be implemented locally and reported to Division two-monthlyin line with QPS frameworkwith appropriately agreed action plans supported3)CIVICA has recently been commissioned by the UHB and will support the development of a dashboard to analyse service user feedback, key performance indicators and Quality outcome measures.	31/12/2022		Overdue		Partial Completion 1) COMPLETED compliments being recorded on datix if receieved 2) All Wales KPI's not yet agreed to incorportae in our performance monitoring locally 3) CIVICA feedback implemented for Care Closer to Home and awaiting first report, wider implementation anticipated in the next 6 months	30/06/2023
Internal	2022.01	CYP Continuing Care	Reasonable	Chief Operating Officer	Low	R5	Implement robust communication mechanisms between the various partnership working forums (e.g., CC Development Group, Regional Integrated Complex Needs Panel, etc).Monitor the effectiveness of these forums and any new joint processes implemented.	Assistant Divisional Nurse / Division Lead QPS	30/11/2022		Overdue		Ongoing - Development of Complex Needs Pathway underway, Interagency collaborative meetings commenced, joint processes in draft form, Consultant Nurse JD in draft, expected to be advertised shortly	30/06/2023
Internal	2022.05	Digital Benefits Realisation	Reasonable	Director of Digital	Medium	R1	R1 - The Health Board should finalise the "front of house" process and enable a process for a holistic prioritisation of programmes.	A draft New Digital Service Request (NDSR) process has been designed to provide transparent onboarding of new work for the informatics directorate. The process sets out how Informatics undertakes and supervises a workflow using agreed standard tools and documentation from triage, through evaluation, discovery & definition to transition to programmes or Service Delivery. This will provide internal assurance of the process and ensures that options are presented to Digital Delivery Oversight Board (DDOB) with a clear assessment of priority and recommendations. DDOB is the body that will make informed decisions on the prioritisation of Informatics programmes and projects. New national programmes will be tracked through the same process allowing the Health Board to locally prioritise and feedback these prioritise back to national	01/06/2023		Overdue		Aug-23: The Director of Digital has completed the review of the Front of House process and this is being finalised prior to approval by the Executive Committee in October which will include strengthening the financial and governance controls	30/06/2023

Internal	2022.06	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	N/A	R2	DAPs should be fully costed to fully determine the total funding required.	Subgroups of the main DPB have been tasked with developing action plans relating to their delegated national initiatives. This work will include costing projects and is currently in progress. Programme/project costs to meetthe interim CO2 reduction targets are currently being	31/03/2023		Overdue			30/06/2023
Internal	2022.06	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	N/A	R4	NHS Wales Organisation's baselines should be adequately scrutinised and challenged, as errors and overreporting has been identified in a few examples to date.	Agree. Net Zero Report data sources, analysis and report generation will be subject to an internal review. The HB have now set up a Decarbonisation Programme Board which incorporates the existing metrics along with additional scrutiny of new projects coming on line within	01/05/2023		Overdue			30/06/2023
Internal	2022.07	Clinical Audit	Limited	Medical Director	Medium	R2	R 2.3 The local clinical audits should be recorded onto AMaT, as is currently being done with national clinical audits.	It is acknowledged that the current process in ABUHB for local audit has lacked structure and formal documentation. AMaT will be utilised for local audit and will enable the development of a formally recognised process for reviewing the organisations performance when reports are published. The AMaT report will include consideration of improvements (planned and delivered) and an escalation process to ensure the executive board is made aware when issues around participation, improvement and risk identification against recommendation are identified. The Clinical audit lead, CSEG and the Assistant Medical Directors will scope how to mandate the use of AMAT. We will agree on a formal process for registering a local audit (which sets out audit lead, reason for audit (e.g. complaint response etc etc), methodology (e.g. how will data be collected and analysed), standard being audited against, timeline, when report due and action to be taken from audit (including where result will be presented). This will be approved in advance – with prioritisation e.g. National audit takes precedence and local audit not addressing a risk issue as lowest priority. All audits will be registered.	01/03/2023		Overdue		Update Aug 2023: It has been acknowledged that the historical process in ABUHB for local audit has lacked structure and formal documentation. This has been updated with the implementation of the web-based audit management and tracking system (AMaT), which is being utilised for local audit. A formally recognised process has been agreed for registering local audits. This includes completion of an audit registration template that needs to be signed off by the Directorate and Division. All audits will be entered onto AMaT. This sets out a clear audit process for audit lead, reason for audit (e.g. complaint response etc), methodology (e.g. how will data be collected and analysed), standard being audited against, timeline and the development of a SMART action. Engagement with Divisional Management teams has been successful. The Clinical Audit Strategy has been shared at meetings and allowed demonstrations of the capabilities of using AMaT. Training for AMaT has been undertaken with staff over the past six months. An annual audit plan, encompassing local audits has been developed for 2023/24 and presented at PQSOC and ARA. This will be updated as local audits are continually added to the plan. The AMaT audit report will include consideration of improvements (planned and delivered) and an escalation	30/06/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	Medium	R1	R1 Consideration should be given to making the supplementary courses mandatory and monitoring related training attendance	a.) The service is currently working with the national team on having a new online learning offering across Wales which includes a fully updated records management module which will be mandatory. b.) We will request, via the clinical information and professional leads, that attendance at the Health Records awareness sessions is compulsory for all ward based staff.At these sessions we will re-iterate the importance of good records management and highlight the issues that are impacting Health Records from the ward.	01/03/2023		Overdue		Aug-23: The National online training incl: Cyber Security & Health Records modules has gone live. IG offer a blended approach to their training and supplementary courses provided are now included in the compliance rates if requested instead of the online version.	30/06/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	High	R2	R2 The importance of maintaining record management quality should be re-iterated to clinical staff, using communications from senior clinical staff and clinical information leads	As per 1.1 above, we will seek to enforce attendance at Health Records awareness Sessions and further re-iterate the professional standards required.	31/03/2023		Overdue			30/06/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	Medium	R3	R3 Records quality checks should be regularly carried out and formally evidenced. Consideration should be given to involve senior	The CNIO will monitor compliance with base line records management.	31/03/2023		Overdue			30/06/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	Medium	R6	R6 It should be ensured that storage conditions for records meet basic standards.	Information on unsuitable storage areas will be presented to the Medical Director every three months by the Data Protection Officer with appropriate risk assessments. Action plan with the Medical Director will be agreed.	31/03/2023		Overdue		Aug-23: Storage aresa review undertaken and areas of mental health identified as requiring improvement previously identified as part of the Mental Health Business Case. Services have engaged with the proposed digitisation of mental health, child health and therapy records and work is underway to begin a programme of work to digitise these records and thereby remove the risk of loss, inappropriate access and storage arrangements. Some MH and some Child Health Records have been acccommodated in a vacated area from previous acute digitisation work to alleviate storage issues within these areas.	30/06/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	High	R7	R7 Patient records security should be ensured at all times.	IG will conduct security audits in remote areas to ensure compliance. The Governance Assurance Group agenda will be widened to include focused audits. The Health records service will work in partnership with this group and there will be a health records representative at Divisional GAG meetings from January 2023. Records management issues to be discussed in the divisional group meetings to create local action plans. Minutes are taken in these forums and progress monitored.	30/06/2023		Overdue		Aug-23: An audit programme is under development in the IG team. The programme of work will commence in early October. Health Records are present in Divisional GAG meetings. Records management issues are discussed and a portfolio register is retained by IG and minutes are taken of the meetings.	30/06/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	Low	R8	R8 Conditions of boxes used for records management should be regularly checked, and boxes which are collapsing should be replaced.	This will be reviewed six monthly and will be an item on the agenda at Governance and Assurance Meetings.	30/06/2023		Overdue			30/06/2023

Internal	2022.12	Records Managment	Limited	Director of Digital	Low	R9	R9 Loose patient records should be properly filed	The CNIO will reinforce this requirement with the ward staff. The process for creating DHR supplementary folders on wards will be shared with all Divisional nurses.	31/03/2023		Overdue		Aug-23: Health Records have found significant amounts of loose filing on wards in RGH & St Woolos. This has been collected and scanned but has a negative impact as each sheet needs to be individually checked, barcoded and scanned rather than as a complete record. The rollout of WNCR has reduced paper generation on wards and the CNIO has been promoting good practice on wards as the system rolls out across RGH. Further implementations at YYF and NHH will further reduce the loose records situation.	30/06/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	Medium	R10	R10 Each ward should adhere to the records management process, and this should be formally monitored (e.g., through exception reports). Specific KPIs should be developed to measure problematic areas	A bespoke report will be requested from Information services and/or DHCW. Where delays in returning documentation are identified via the report, these will be flagged and escalated to ward and clinical management.	30/06/2023		Overdue			30/06/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	Medium	R11	R11 Issues of records management process slowdowns should be investigated and escalated when required.	As per 4.1 above, a bespoke report will be developed. However, staffing resource will be required to check if discharges have been actioned and records have been returned. The need for additional resources will be considered	31/03/2023		Overdue			30/06/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	Medium	R12	R12 Data recording in Datix should be improved to ensure a more accurate reporting on missing / lost records.	Reinforcement of reporting through Datix will be cascaded to ward staff in training sessions and Governance and Assurance Group meetings.	30/06/2023		Overdue			30/06/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	Medium	R14	R14 A formal process should be developed and adopted across the Health Board to share, escalate and resolve record management issues.	a.) The Governance and Assurance group will provide the forum for divisions to report records management issues. b.) A Health records representative will attend these sessions and work with the divisions going forward to improve records management. Progress will be monitored and reported quarterly and recorded on the centrally held portfolio register for each division. c.) Clinical coding teams report issues via the Health Records management monthly meeting and sit on the Governance and Assurance group. As part of this process. Clinical Coding will highlight areas where loose records have been identified.	31/03/2023		Overdue			30/06/2023
Internal	2022.12	Records Managment	Limited	Director of Digital	Medium	R15	R15 We recommend the undated/ expired documents are reviewed, updated and ratified as a matter of priority.	Nurse Staffing Levels Wales (2016) Act Operational Framework and Escalation Process will now have approval date added and next review date.It is acknowledged that "The Protocol for requesting, authorising & booking bank and agency clinical workers Standard Operating Procedure" expired in 2017. The practice contained in the document remained the same up until the Covid Pandemic. During this time priority was to secure clinical staff to ensure our wards and our staff were safe. Subsequently, in 2022 the bank Rules have been reviewed and issued. This protocol will be reviewed in line with the implementation of safecare.	01/03/2023		Overdue		Jun 23: Approval and review date added to NSLWA and updated protocol published.	30/06/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Low	R1	A formal SOP should be defined that sets out how the RPA process is to be managed. The operational service model should be fully defined and the terms of reference for the governance board reviewed and updated.	Upon successful investment case being made this will be addressed as part of the transisition to service delivery	01/06/2023		Overdue		Aug-23: 2 posts funded for a permanent team.Recruitment underway. Team will sit within Softwrae development as part of Integration services	30/06/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Medium	R2	Benefits realisation should be established as part of the go-live for automated processes, with the relevant department being required to monitor and confirm the benefits.	Benefits realisation is identified and confirmed by relevant departments and this will now be formally monitored and confirmed by the governance board. This is in part contingent on a successful business case.	28/06/2023		Overdue		Aug-23: Service request forms and opportunity assessment form redesigned to provide better profiling of benefits. Process agreed by RPA Board for requesting service Finance BPA assurance of benefits before automations are agreed	30/06/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Medium	R3	Consideration should be given to establishing a benefits sharing framework for cash releasing savings that would enable the RPA function to be self-sufficient.	This is not a unique issue to RPA but reflects the need for benefits realisation to include (when corroborated and confirmed) sharing of benefits including financial where this is the case. In order to mitigate the risk of priority based on ability to pay the process needs to be owned and curated at health board level rather than between departments. This recommendation will be considered in	31/03/2023		Overdue		Aug-23: Service request forms and opportunity assessment form redesigned to provide better profiling of benefits. Process agreed by RPA Board for requesting service Finance BPA assurance of benefits before automations are agreed	30/06/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Medium	R4	The Health Board should seek to complete recruitment and staff the RPA team accordingly.	A revised business case is expected to be submitted to Executive colleagues in Q4.	01/03/2023		Overdue		Aug-23: RPA escalation SBAR presented to Exec Board in March 2023. 2 posts agreed.	30/06/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Medium	R5	The Health Board should consider the purchase of additional robot capacity.	The business case for submission in Q4 provides an option also to increase capacity of automation.	01/03/2023		Overdue		Aug-23: RPA escalation SBAR presented to Exec Board in March 2023. Additional robot purchase not supported pending rebaselining of planned automations benefits	30/06/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Medium	R6	Consideration should be given to increasing the level of ring fencing for specific robot time for time constrained processes as part of the ongoing development of the RPA service	The business case for submission in Q4 provides an option also to increase capacity of automation.	01/03/2023		Overdue		Aug-23: Peak day time capacity consumes all current robot capacity. Additional robots have been procured from non RPA budgets to support critical functionality. The RPA architect continues to reprofile activity to ensure automations are deployed optimally to allow additional automations not dependent on in hours working to be undertaken.	30/06/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Medium	R7	The awareness of RPA and the change management process should be strengthened as RPA moves into an operational service. All services should be made aware of the requirement to notify Informatics of changes to any system that may interact with the robots.	Part of the transitional arrangements to operational services will be refined and robust service management arrangements. This is subject to a successful business case.			Overdue		Aug-23: Transition to BASU will be undertaken when posts are appointed q3 2023	30/06/2023

Internal	2022.15	IT Strategy	Reasonable	Director of Digital	Medium	R2	The role of the CCIO and CNIO should be fully defined.	2.1a The CCIO currently has an AMD role profile. There has been discussions for some time in terms of role design and accountability with the CCIO MD CEO and CDO. A model role profile based on the Faculty of Clinical Informatics example has been agreed and is now being localised. The CNIO has a full role profile and agreed Job	01/06/2023		Overdue		Aug-23: CNIO aspects of this have been met	30/06/2023
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	Medium	R3	Leads within divisions should be established to work with the CCIO / CNIO	The principle of Divisional Leads is accepted by the health board. The proposition now needs to be explored and defined in a proposal by the CCIO and CNIO to the Digital Delivery Oversight Board.	01/06/2023		Overdue		Aug-23: Clinical Informartics Council in place and meeting scheduled every 6 weeks, how service pressures have resulted in over half the meetings this year cancelled. More formal job planning needed to release resources to attend	30/06/2023
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	Medium	R4	Work should be undertaken to embed the Clinical Informatics Council and encourage participation therein	Agreed. The CCIO and CNIO will revisit the membership and Terms of Reference for the Clinical Informatics Council which will be included as part of	01/06/2023		Overdue			30/06/2023
Internal	2022.16	Financial Sustainability	Reasonable	Director of Finance and Procurement	Medium	R1	All delegated budgets should be formally accepted. Non-acceptance of a delegated budget should be reported to the Finance and Performance Committee and / or the Audit, Risk and Assurance Committee	Accepted for Executive level delegation letters	01/05/2023		Overdue			30/06/2023
Internal	2022.17	Risk Management	Reasonable	Chief Operating Officer	Low	R1	The Complex and Long Term Care Division should report the full risk register, on a periodic basis, to the Divisional Quality, Patient Safety and Experience Group	Agreed. The Complex and Long Term Care Division will report the full risk register to the Divisional Quality, Patient Safety and Experience Group	01/04/2023		Overdue		Only high risks are requested by QPSOG, full register available when requested / required.	30/06/2023
Internal	2022.17	Risk Management	Reasonable	Chief Operating Officer	Medium	R2	The Complex and Long Term Care Division should ensure that there is no additional risk exposure through the current approach of recording divisional risks	Agreed. The Complex and Long Term Care Division will ensure there is no additional risk exposure through the current approach of recording divisional risks	01/04/2023		Overdue		Risks are discussed on a regular basis via numeorus daily / weekly meetings.	30/06/2023
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	High	R1	Where a Health Board policy is to expire that an extension to the document is formally granted, with a revised review by date established. Such policy extensions should be reported to the Board or designated Committee and checks made to ensure that the policy remains as relevant as possible, pending any formal review.	The Health Board's clinical policies have a review date rather than an expiry date, and whilst the review date may have elapsed, the policy remains extant and does not require a formal extension. However, whilst the Policy remains extant, we recognise there may be differences between the Policy and current practice. Therefore, the current process will be reviewed and compared to the existing policy. Where gaps are identified, these will be risk assessed and mitigation implemented to reduce risk to an acceptable level. We anticipate this will include an interim update to the Policy. Following this process we will provide assurance to the QPSOG over actions to be implemented, with regular updates provided on implementation status.	01/05/2023		Overdue			30/06/2023
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	High	R1	The Discharge Policy is updated, approved and reissued, to reflect current practice and approach to discharge planning adopted by the Health Board (Medical Fit Date for Discharge, simple and complex case approaches, and the management of the Complex List) and the related roles and responsibilities of staff.	In the interim we will identify the gaps between current practice and the current policy and ensure that it is updated. We will then ensure the Policy is approved by the appropriate Committee. Once the All-Wales Policy is published, we will ensure that any requirements are incorporated into the Health Board's Policy. The revised policies will be re-issued with training overseen by the Head of Discharge and Divisional Nurses. We will continue to monitor the implementation of the policy and update training requirements as required.	01/05/2023		Overdue			30/06/2023
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R3	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	Agreed, the University Health Board will seek evidence of timely payments from the Supply Chain Partner as part of monthly progress reporting	01/09/2023		Overdue		The PBA will be implemented from September 2023.	30/06/2023
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R5	At future projects Contracts should be executed prior to the commencement of works / duties.	Agreed -Future Projects Contracts will be signed prior to the commencement of works	01/03/2024		Overdue		Derogations were signed off by the pervious Head of Operations. VT signed off design proposals and the scrutiny process required input from Shared Services to the technical design. Discussion could not place with the Linac Supplier until after FBC submission and this has subsequently led to a number of reviews of the Bunker Layouts	30/06/2023
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Low	R5	At future projects All contracts should be dated	Agreed - Future Projects - Contracts will be dated.	01/03/2024		Overdue		At this point in time the process for the provision of collectoral warranties has not required to be actioned as the relevant works have not be completed	30/06/2023
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R6	User sign-off of the design and derogations should be formally recorded.	Agreed, Design & derogations will be formally and finally signed off by users to reflect very recent changes requested by the supplier of the Linear Accelerator medical devices	01/06/2023		Overdue		Aug 2023: Derogations were signed off by the pervious Head of Operations. VT signed off design proposals and the scrutiny process required input from Shared Services to the technical design. Discussion could not place with the Linac Supplier until after FBC submission and this has subsequently led to a number of reviews of the Bunker Layouts.	30/06/2023
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R7	The UHB should seek to obtain the necessary collateral warranties at the earliest opportunity.	Agreed, the necessary collateral warranties will be obtained at the earliest opportunity.	01/06/2023		Overdue		Aug 2023: At this point in time the process for the provision of collectoral warranties has not required to be actioned as the relevant works have not be completed. Not currently at the point of issuing warranties.	30/06/2023
Internal	2022.22	RGH Redevelopment & Expansion of Endoscopy Services	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R6	At Future Projects The contract strategy should be fully evaluated and considered (within the Business Justification Case or extant).	Future business cases will include reference to a contract strategy	01/05/2023		Overdue		Aug 2023: This is a future action for future projects	30/06/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Medium	R3	Consideration should be given to make the electronic recording fit for dementia services. For example, add or change menu structure or introduce a dedicated field to highlight dementia diagnose.	Workstream 5b leads, along with Performance Team support, will review the electronic information and ensure the recording is appropriate for dementia services going forward	01/08/2023		Overdue		UPDATE JULY 2023: Dementia webpages are being reviewed to ensure the availability of the document digitally.	30/06/2023

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Priority	Recommen-dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Proposed Revised Deadline	Due	If closed and not complete please provide justification and ensure evidence is avaliable	Progress of work underway	Reporting Date
Internal	2017.00	Health and Safety (2017/18)	Limited	Director of Therapies and Health Science	High	R1	R1 The Health Board should develop a methodology / approach for establishing and undertaking an annual programme of workplace inspections. In particular, it should set out: How service areas / wards are selected for an inspection, including risk analysis, previous findings, incidents and Datix reporting; the approach to the inspection, including which health and safety areas are included. For example, there may be numerous priorities from one year to the next; methodology for undertaking the inspection, i.e. the process for completing one from start to finish; how assurance is provided to the sub-committees of the Board over how the programme of work is devised and that it is completed on schedule or otherwise; and findings from the workplace inspections are identified and acted upon.In addition, the Health Board should ensure that a programme of workplace inspections is developed and delivered in accordance with section 10.1 of the Occupational Health and Safety Policy. For example, the Health and Safety Committee may stipulate that all high risk areas are reviewed each year. Furthermore, if the programme is delivered late, then the Committee should receive assurances, together with an action plan for delivery to be returned to schedule.	An ABUHB health and safety monitoringmanual will be developed. This will include a two year plan which outlines the audit/inspection delivery programme.The manual, including programme willbe presented at the ABUHB Health and Safety Committee in March 2018 for approval. The anticipated start date of the monitoring is 1stApril 2018.Future monitoring of the health and safety audit/inspection compliance will be presented via Divisional dashboards with an overview being presented at the ABUHB Healthand Safety Committee.	30/04/2018	31/03/2024	Overdue		March 2023 - A programme of respiratory protection equipment (RPE) inspections has been developed and commenced in October 2022. The plan to inspect all in-patient clinical areas by March 2023 is approximately 95% complete. The inspections conducted by the Corporate Health and Safety Department are recorded via the AMaT system enabling the outcomes to be analysed & reported to relevant forums i.e. Divisional QPS meetings, Site Management groups, ABUHB Health and Safety Committee, QPS Operational Group etc. A programme of health and safety environmental inspections will commence in May 2023 and will target clinical areas. The programme will be carried out over a two-year cycle, commencing with the older estate or those that have been subject to significant change i.e. Royal Gwent Hospital and Nevill Hall Hospital. The inspections will be conducted by the Corporate Health and Safety Department and recorded via the AMaT system enabling the outcomes to be analysed & reported to relevant forums i.e. Divisional QPS meetings, Site Management groups, ABUHB Health and Safety Committee, QPS Operational Group etc. The Corporate Health and Safety Department are also planning the development of self-assessment inspection tools for wards and departments to complete their own localised health and safety	30/06/2023
Internal	2017.00	Health and Safety (2017/18)	Limited	Director of Therapies and Health Science	High	R2	R2 The Health Board should ensure that each area has completed an up-to-date health and safety risk assessment, by a trained co-ordinator. The risk assessment process should be overseen by the Health and Safety team, to ensure that it is completed in accordance with the Occupational Health and Safety Policy.In addition, the Health Board should review and refresh the list of safety co-ordinators and continue to do so following the initial update.The Health and Safety team should provide assurance and regular updates to the Health and Safety Committee over the status of risk assessments.	The monitoring of local risk management systems, including risk assessments will be included in the audit/inspection programme.The status of risk assessments will be reviewed and compliance reported via a dashboard to the ABUHB Health and Safety Committee and relevant Divisional forums.Further consideration is required to the utilisation of software to record and manage risk within the Health Board.	30/04/2018	31/03/2024	Overdue		March 2023 - The Corporate Health and Safety Department have engaged with Divisions to ensure risks are recorded, monitoring and managed using the Datix system. This has improved the quality of health and safety risks on the system. The Corporate Health and Safety Department are reviewing all high risks (risk rating of 12 or above) recorded on the Datix system and where necessary support local managers to mitigate the risk. The programme of health and safety environmental inspections will support the identification and review of health and safety risks across the Health Board. Health and safety risks will be regularly reported to the ABUHB Health and Safety Committee to enable active monitoring. A revitalised education programme of health and safety risk assessment training has been approved and commenced in 2023. The register of risk assessors within the organisation has been reviewed and areas needing support will be prioritised for attendance at the risk assessment training.	30/06/2023
Internal	2017.00	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies and Health Science	High	R2	R2 A clear robust control mechanism should be established by the divisions / directorates demonstrating the consideration and delivering of applicable training,aligned to medical equipment and devices. Training records should also be uploaded onto ESR.The poor mandatory training compliance rates with regard to infusion devices / pumps should be addressed as a matter of urgency.	From a Divisional perspective, the cascade training provided at ward level has not raised any particular safety issues, although with the increasing use of bank and agency staff, consideration should be given to accessible on site training for these members of staff. The Health Board to consider establishing a catalogue of equipment that needs specific training to operate, alongside a database of staff compliance.	31/03/2018	30/04/2023	Overdue		November 2022 - An infusion device training strategy was presented to the April Medical Devices Committee. A training implementation plan is now under development to support the roll out of a more resilient process in line with the strategy. This aims to assure that training provision can match the need associated with both attaining and maintaining compliance levels at or above the standard. Unfortunately due to staff sickness absence, further development work has not been fully realised. ▪ Recruitment to now vacant QPS Infusion Device Service Training Manager post is in progress. ▪ An exercise has been started to consolidate the training records for infusion devices and provide a compliance dashboard. Piloting this will inform a plan to capture monitoring of training compliance for other groups of medical equipment.	30/06/2023

Internal	2021.00	Gifts, Hospitality and Declarations of Interest	Reasonable	Director of Corporate Governance	Medium	R1	R1 The Health Board should add an additional section to the declaration of interests form detailing any additional action required to mitigate risk. These measures should be implementedand monitoredby the individual's line manager.b.The Policy and accompanying processes should be updated to support the changes required to mitigate the risk.	a.As identified, whilst there is adherence to the policy, the recommendation provides an opportunity to improve the mechanismswithin departments. To facilitate this the Health Boards ESR will be reviewed to determine how declarations can be digitally captured toenable improved conflictmonitoring and management.Where ESR may not be used (e.g. by Independent Members) then the manual form will be updated to reflect the recommended improvements. b.The policy and process documents will be updated to reflect the amendments.	31/10/2021	31/03/2024	Overdue		Arrangements for the declaring of interests, gifts and hospitality Included as a governance priority within the IMTP 2022-25 August 2023: Due to gaps within the corporate governance team this work has been delatyed. Recruitment has recently taken place with posts expected to be filled by November 2023. This work should therefore be completed in Q4, 2023/24	30/06/2023
Internal	2021.00	Gifts, Hospitality and Declarations of Interest	Reasonable	Director of Corporate Governance	Medium	R2	R2 The procedures for receiving and processing declarations made should be formalised and include:i.the use of a shared mailbox for all declarations;ii.details of the process for receiving and processing declarationsand the associatedtimescales;iii.details of due diligence to be undertaken on completed declarations;iv.timeframes for reminders to be issued in the event where previous declarations have been submitted; andv.details of any completeness checks to be undertaken to determine if there are missingdeclarations.	To facilitate all recommendationsthe Health Boards ESR will be reviewed to determine how declarations can be digitally captured and enabled toimprove receipt and management. This will facilitate improved recording across the organisation, allow automated reminders, and provide reports to Divisional managers for completion and adherence checks and missing declarations.In addition, where ESR may not be used (e.g. by Independent Members) then the manual form will be updated to reflect the recommended improvements.	31/10/2021	31/03/2024	Overdue		Arrangements for the declaring of interests, gifts and hospitality Included as a governance priority within the IMTP 2022-25 August 2023: Due to gaps within the corporate governance team this work has been delatyed. Recruitment has recently taken place with posts expected to be filled by November 2023. This work should therefore be completed in Q4, 2023/24	30/06/2023
Internal	2021.07	Occupational Health	Substantial	Director of Workforce & OD	Low	R1	The Health Board should consider:a)Automating key aspects of the processes, to reduce the workload for the Occupational Health Team. For example, auto-generation of emails / letters for referrals, self-selection of referral appointmentsby staff or a self-directed referral to an appropriate professional.b)Updating resilience / continuity plans to assist with increased demand in the future, to include reallocation of team members, setting up amended work schedules, reduced appointment slots, allocation of clerical staff to clinical staff to maximise clinic availability, overtimeoptions, re-focussing of service prioritiesand / or streamlining of processes to a bare minimumon a temporary basisetc.c)Engaging in any future All-Wales reviews of occupational health serviceswithin the NHS.	a.It is planned that the current management referral process will move from paper referral and Occupational Health response in letter format to an online referral system and subsequent report to managers in 2022. The service is currently part of an All Wales task and finish group developing this. Once implemented it should remove several administration stages of the current process. The recommendation for staff to be able to self–select would miss out the essential clinical triage process to allocate Occupational Health clinical staff resources appropriately. b.Occupational Health consistently review its skill mix and resources to meet the demands of the service. Through periods of higher administration demand for example Covid 19 PCR results and the annual Flu programme additional administrative hours are sourced. This reduces any impact on routine Occupational Health function. A detailed service review is planned for Quarter 2 in 2022 which will incorporate the recommendation of the Occupational Therapy scoping exercise which commenced on the 1st November and is planned to conclude on March	31/03/2022	06/10/2023	Overdue		Aug 2023: A new automated system OPASG2 is coming in on 20th September which will bring the following benefits in addition we are engaging with all Wales review and systems procurement. Applicants complete an online pre-employment health declaration – removal of paper forms! Integrated functionality between OPASG2 and the Trac recruitment system. Therefore, OH results update the applicant record directly in Trac. Transparency of applicant progress with timely updates visible in Trac such as an OH appointment booking. Reduced waiting times for Occupational Health Clearances	30/06/2023
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R2	R2 The Health Board should seek clarity over why the requests made to DHCW and the SMBfor an integrated electronic process cannot be delivered.The Health Boardshouldcarryout an analysis to fully identifyits needsfor a Radiology system and seek to include these within WRIS or any future system.	We have tried to seek clarity and not had a full response.Arequest for CWS to include WCP for radiology reporting in the platformhas been formally raised. We haveraised the need for end to end requesting as a health board to the collaborativeboard for RISP project.	31/03/2022	30/09/2023	Overdue		Aug 2023: The UAT has been passed and is with clincial apps and is being trialled in Primary Care on the 11/09/2023. There are discussion amonst informatics about integrating the WCP requesting within CWS and we have done early scoping exercises with a bussiness analysist revewing this currently. May 23: The UAT has been passed and is with clincial	30/06/2023
Internal	2021.17	Corporate Governance: BAF	Reasonable	Director of Corporate Governance	Medium	R4	R4. We recommend that the Health Boarddevelops a periodic report commenting on compliance/ the effectiveness of the BAFprocessand reports this to an appropriate committee.	The Health Board accepts this recommendation and will incorporate a review of the effectiveness of the BAF into Board evaluation and committee self assessment processes.	31/07/2022	31/03/2024	Overdue		August 2023: Risk Management Stratgey and Board Assurance Framework processes under review. Revised strategy due to Board in Q4, 2023/24.	30/06/2023

Internal	2021.24	Flow Centre	Reasonable	Chief Operating Officer	Low	R3	R3 The Flow Centre Team should develop key performance indicators to help improve the delivery of the service, manage key risks and to help develop staff.	With recent changes in clinical and operational leadership of the Flow Centre a focus will be on creating these key performance indicators (KPI) and stabilising the services as we recover from the impact of COVID. Create operational KPI for Pre-Hospital Screening. Create clinical KPI for Intersite transfer service. Review the clinical and operational model of the Flow Centre	30/09/2022	31/12/2023	Overdue		Mar 23•Some KPIs have been created, reviewed each week at SLR and will form the basis of the Flow Centre Review currently taking place	30/06/2023
Internal	2021.24	Flow Centre	Reasonable	Chief Operating Officer	Medium	R4	R4.1 We recommend that the Flow Centre Team review and update the business continuity plan, where required.	The business continuity plan is being reviewed and updated currently.	30/06/2022	31/12/2023	Overdue		Aug 2023: In light of recent BC events we will review update and test this accordingly Mar 23 •The BCP has been created/updated and is due for a further review in light of recent IT risks and the joining of the Urgent Care Division	30/06/2023
Internal	2021.24	Flow Centre	Reasonable	Chief Operating Officer	Low	R4	R4.2 We recommend that the Flow Centre Team periodically test their business continuity plan and update it with learnings from the exercise(s).	A planned test of the business continuity plan will be initiated by the target date. An unplanned test of the business continuity plan will be initiated by the target date	30/10/2022	31/12/2023	Overdue		Aug 2023: In light of recent BC events we will review update and test this accordingly Mar 23 •This is on hold until we return to our call centre.	30/06/2023
Internal	2021.26	Facilities - Care After Death	Reasonable	Chief Operating Officer	Medium	R3	R3 The Care after Death Team should determine if the software delivers sufficient benefits in excess of the potential risks. If not, then alternative software / system should be procured, to include some / all of the following features:•remotelyaccessible acrossall sites, at all times;•update immediatelyfollowing any change inputted;•link to keysoftwarewithin the Health Board,to minimise manual data entry;•produce management information / a dashboardand other relevant information (e.g. patient location);•raise warnings where breaches to the SOPs are imminent, e.g. capacity, temperature (if recommendation three is adopted) warnings;•a full audit trail including access information and data changes;•support profile levelsto facilitateaccess control; and•be fully compliant with the Health Board and DHCWshared service software requirements.	It is acknowledged that the current system does present the Health Board with a risk due to the issues as identified within the audit. The issue of the current & inherited database being unfit for purpose is acknowledged; the Estates & Facilities Divisionwill now engage with suppliers to identify a suitable replacement software system. A three-month window to identify supplier, design a system and implement is believed to be a significant challenge. It is expected that this work may take up to a six-month period.	30/09/2022	30/04/2023	Overdue		Update August 2023 - np new software procured by W&E. A meeting with informatics took place on 18/08 to discuss current database. Agreed Informatics do not have the expertise to make any significant changes to the system but have committed to maintain the system by best endeavours. Agreed that Qlik will be used to produce reports. Nov 2022 Alternative software solution has been procured via Synbiotix. Ongoing liaison between Synbiotix, IG & IT infrastructure teams to ensure all relevant safety aspects are mapped out. Further development work alongside Information Governance team to understand the barriers to uploading patient information is being undertaken.	30/06/2023
Internal	2021.27	Waste Management	Reasonable	Chief Operating Officer	Medium	R1	1.1 Ensure that the Waste Management Policy has been reviewed/updated and reflective of the above findings. That the updated Policy is underpinned by formal Board Level approval with all key elements of WHTM 07-01 guidance incorporated.	1.1 The Waste Management Policy will be reviewed/updated and formally approved by the Board.	31/10/2022	30/07/2023	Overdue		Policy is currently being reviewed/updated with new Director prior to engagement with wider stakeholders.	30/06/2023
Internal	2021.27	Waste Management	Reasonable	Chief Operating Officer	Medium	R1	1.3 Out-of-date policy / procedural documents published online should be updated.	1.3 All online policies and procedures will be reviewed and updated where necessary.	31/10/2022	31/08/2023	Overdue		Aug 2023: Waste Policy to be uploaded to Sharepoint once signed off. Date for publication will be subject to Divisional sign off. Waste Policy to be uploaded to Sharepoint once signed off. Date for publication will be subject to formal sign off internally	30/06/2023

Internal	2022.01	CYP Continuing Care	Reasonable	Chief Operating Officer	High	R1	CloseHealth Board monitoring ofthe key risks facing the CCNS to ensure:•appropriate action continues to be taken; and•support is provided to the CCNS as required	1)Engagement with families and staff in a review of service models –utilising co-production and with a compassionate leadership lens explore options of "out of family home" models of care, which may meet needs of child/young person more effectively, optimise management of scarce resources and support retention of staff.2)Workforce review to identify skill mixedworkforceresource required to deliver safe service across the various linesof commissioned service e.g.Continuing Care, Special Schools, Children's Out Patients, Clinical/Care closer to home3)Business Case/Service Review to establish options of further efficiency and priority with theidentification ofdiscrete financialbudgetlinesto meet assessed and agreed service priorities4)Developing new roles/skill mix within the Children's Community Nursing Service to enhance service provision5)Partnership Board/Welsh Governmentrecommendation required to determine the prudent delivery of care described as ancillary and incidental care needs, and multi-agency responsibilities initsdelivery.This will aid the alignment of Value-Basedhealth	31/03/2023	31/12/2023	Overdue		Aug 2023: Awaiting sign off of Bridgeview before we can engage with our families to explore out of home model of care. 2. Workforce review completed and skill mixed model identified. Awaiting sign off of Band 4 before implementation. 3. Business case submitted detailing risks of service reduction in each area. New financial envelope was estimated from a period of high vacancies, high sickness and complaints from families due to a reduction in their statutory respite. 4. Currently no scope to develop new or additional roles within the CCNS due to financial constraints, however skills mix model has been developed through the workforce work to enhance the skills and allow a "grown our own" model for sustainability in the future of the service. 5. Ongoing discussions due to social care and health interperating the recommendations differently.	30/06/2023
Internal	2022.04	Agile Delivery	Not Rated	Director of Workforce & OD	High	R1	An overarching agile working plan should be developed. It should include:•An overarching vision (this could be taken from the already published Agile Working Framework).•A set of SMART goals/ milestonesto achieve this vision.•A list of Welsh Government targets which need to be achieved.•All relevant services areas should be included and engaged with.A benefits listshould be developedto sit alongside the planwhich details how the Health Board will measure its success against each of the goals. The listshould include quantifiable measurements which can be analysed to confirm the success of each goal.	Agreed, the overarching HBand WG visionwill be added to the developed Programme Plan. Overarching SMART goals will be articulated with more specific goals once the assessment and review of the estates has been undertaken.	30/11/2022	30/11/2023	Overdue		AUG 2023: An agile/vision has been drafted and presented to the Executive team in June 23. This has been further updated to reflect options around roll out and alignment with an Estate Strategy. This will be presented to the Executive Team in September 23. The originally proposed estate agile asssessments continue to be undertaken until agreement of vision and options. Nov 2022 Plan - will reconfirm the vision and SMART objectives in programme delivery board December 2022, then taken forward to executive Committee and Board for final endorsement	30/06/2023
Internal	2022.04	Agile Delivery	Not Rated	Director of Workforce & OD	Low	R2	Confirm with the Executive Team that the agile working principles noted within the Agile WorkingFrameworkstill represent the current vision. If amendments are required, the Framework should be updated.	An agreed vision for agile working had been agreed by the Executive Team previously and had developed over the response to the COVID pandemic. There are agreed priorities in place for implementing this vision. However, to work beyond the agreed priorities and to embed agile working strategically into Health Board plans it is agreed that this is a good time to re-new the vision.	30/11/2022	30/11/2023	Overdue		AUG 2023: An agile/vision has been drafted and presented to the Executive team in June 23. This has been further updated to reflect options around roll out and alignment with an Estate Strategy. This will be presented to the Executive Team in September 23. The originally proposed estate agile asssessments continue to be undertaken until agreement of vision and options. Mar 23 Proposed agile vision presented to the Executive Committee on 09 February. Drivers and enablers were presented as well and hybrid working and setting up a network of hubs to facilitate the reduction in personal office/desk space.	30/06/2023
Internal	2022.10	Newport HWB Centre	Reasonable	Chief Operating Officer	Medium	R2	R2 The role and responsibilities of the Primary Care & Community Estates Programme Board, in acting as the Project Board for major Primary Care projects, should be clearly defined in the Terms of Reference.	Agreed. The role of the Primary Care & Community Estates Programme Board, in acting as the Project Board will be defined and documented.	01/02/2023	31/10/2023	Overdue		Aug 2023: The PC Programme Board did not meet after April 2023. A new SRO has been identified and a separate PB has been arranged for 17th October	30/06/2023
Internal	2022.10	Newport HWB Centre	Reasonable	Chief Operating Officer	Medium	R3	R3 The Primary Care & Community Estates Programme Board should meet with the agreed frequency (6-weekly) as a minimum to ensure sufficiently regular oversight of the major projects within its remit.	Agreed	01/01/2023	31/10/2023	Overdue		Aug 2023: The PC Programme Board did not meet after April 2023. A new SRO has been identified and a separate PB has been arranged for 17th October	30/06/2023
Internal	2022.10	Newport HWB Centre	Reasonable	Chief Operating Officer	Medium	R4	R4 The constitution and capacity of the Primary Care & Community Estates Programme Board to effectively execute the Project Board role for all the Primary Care projects within its remit should be reviewed and confirmed.	Agreed. The governance structure will be reviewed	01/02/2023	31/10/2023	Overdue		Aug 2023: The PC Programme Board did not meet after April 2023. A new SRO has been identified and a separate PB has been arranged for 17th October	30/06/2023
Internal	2022.10	Newport HWB Centre	Reasonable	Chief Operating Officer	Medium	R8	R8 A report should be tabled at the next Primary Care & Community Estates Programme Board meeting, presenting an update against each Gateway recommendation, and identifying any actions still outstanding.	Agreed	01/01/2023	31/10/2023	Overdue		Aug 2023: The Gateway Report was presented to a previous incarnation of the Project Board. It will be submitted again to the newly convened PB on 17th October. Remit of the Capital Planning Team	30/06/2023

Internal	2022.10	Newport HWB Centre	Reasonable	Chief Operating Officer	Low	R15	R15 The Project Bank Account should be implemented as soon as possible.	Agreed. The UHB is awaiting a list of sub-contractors from the SCP who wish to join the PBA.	01/02/2023	30/09/2023	Overdue		Aug 2023: The PBA will go live in September 2023 Remit of the Capital Planning Team	30/06/2023
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Medium	R1	R1 The Health Board should review the types of policy documents retained and hosted, to determine if each of them should adhere to the Policy, for example, departmental standard operating procedures to be managed entirely within the respective division. Alongside this review, the document owner should be determined to ensure the responsibility remains with the most appropriate individual.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), clarity will be provided on which WCDs are to be held centrally and which are to be managed within services and teams. A review of the central base (881 documents) is underway, working with divisions, to review the status of each document and respective owners.	31/03/2023	30/09/2023	Overdue		Jun 23 - The Policy on Policies is currently being reviewed and as part of the review the scope of WCDs to be held centrally. The proposed scope is that only organisational WCDs will be held and managed centrally; all local polices and procedures will be managed within respective Divisions/Departments. This will be shared with key stakeholders in Q2 2023/24 for comment.	30/06/2023
Internal	2022.17	Risk Management	Reasonable	Director of Corporate Governance	Low	R2	The Health Board should clarify how Divisions will record risk in the meantime.	The Health Board is currently revising its Risk Management Policy which is expected to be presented for endorsement at the May 2023 Board meeting. Within the revised Strategy, refined guidance on capturing and recording of risks will be included.	01/05/2023	31/03/2023	Overdue			30/06/2023
Internal	2022.18	Monitoring Action Plans	Reasonable	Director of Therapies and Health Science	Medium	R1	A SOP for how to manage and respond to HSE reports should be created. It should include, but not limited to: • how HSE reports are distributed to responsible staff within the Health Board; • who has designated responsibility for coordinating responses to HSE reports; • the escalation process for issues identified as part of HSE inspections; • who/which committee has responsibility for monitoring actions raised as part of the HSE reports and the process for doing this; and • when assurance reports should be produced and which committee should review them	The Health Board agrees with this recommendation. An SOP on the management of HSE reports will be developed and presented to the ABUHB Health and Safety Committee in May 2023	01/05/2023	31/10/2023	Overdue		August 2023: The development of an SOP on the management of HSE reports is being discussed at a national level via the All Wales Health and Safety Management Group. Following discussion at the natiional meeting in September 2023 an SOP will be prepared and shared with members of the Health and Safety Committee to share across the Health Board.	30/06/2023
Internal	2022.18	Monitoring Action Plans	Reasonable	Director of Nursing	Low	R2	Management should review the number of actions raised within the HIW reports and the number of actions noted within the reports sent to committees for accuracy. Management should ensure no actions have been missed from the HIW report	The Health Board agrees with this recommendation. An update to the SOP will be developed to ensure a Quality Assurance check is undertaken, confirming that all actions have been captured and referenced	01/05/2023	31/10/2023	Overdue		August 2023: SOP updated to include the undertaking of Quality Assurance checks. In process of moving all inspections onto AMAT. The system will automatically generate reports, to include number of actions identified."	30/06/2023
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	Medium	R1	See Newport East Health and Wellbeing Centre Audit Report MA2 issued December 2022.	Agreed. The issue was raised at the February meeting of the Programme Board in the absence of the Director of Primary Care, Community and Mental Health services. Proposed to separate the Project Board function from the wider remit of the Programme Board.	01/06/2023	28/08/2023	Overdue		Aug 2023: A new SRO has been identified and a separate PB has been arranged for 28th August	30/06/2023
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	Medium	R4	Management should obtain signed lease agreements with relevant parties at the earliest opportunity	Agreed. The provision of signed lease is being actively addressed so that they are in place well before the planned occupation of the building.	01/06/2023	31/10/2023	Overdue		Aug 2023: NHS Shared Services continue to progess the leases for GMS, Dental and Pharmacy accommodation	30/06/2023
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	Low	R6	Quantified, measurable and achievable targets should be set to appraise project benefits.	The Benefits register will be updated to reflect quantified targets as at the end of March 2023.	01/06/2023	31/10/2023	Overdue		Aug 2023: This needs discussion at the newly constituted Project Board	30/06/2023
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	Low	R7	The Cost Adviser should provide assurance that appropriate sampling has been made of supporting documentation for costs claimed in respect of Plant and Materials (utilising an Open Book approach as specified at the Project Execution Plan).	Agreed. The Cost Adviser has been requested to provide such assurance.	01/06/2023	30/09/2023	Overdue		Aug 2023: This is outstanding	30/06/2023
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R3	Deeds should be signed as a priority and the Project Bank Account established in line with Wales Procurement Policy Note WPPN 04 which is supported by the requirements of the University Health Board's Standard Financial Instructions section 15.4.8.	Agreed, the Project Bank Account Trust Deed was signed and returned to the Supply Chain Partner (SCP) on 15th March. Implementation usually takes 4 to 6 weeks including the sign up of Sub Contractors. As things stand no Sub-Contractors wish to join the PBA, evidence of refusal has been requested	01/06/2023	30/09/2023	Overdue		Aug 2023: The PBA will be implemented from September 2023.	30/06/2023
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Medium	R2	There should be a programme of work implemented, to undertake an assessment of the environmental suitability of wards that provide beds for patients with dementia	This will be discussed at the In-Patient Hospital Group on 28th of June and confirm who leads on this	01/06/2023	31/01/2024	Overdue		UPDATE JULY 2023. Audit recommendations discussed at meeting. Agreement that a review of the in-patient action plan will be undertaken in September 2023. A dedicated inpatient workshop focussing on the All Wales Dementia Friendly Hospital Charter will be held in November 2023. This will include a review of the resources required to undertale an environmental audit of in patient	30/06/2023

Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Low	R2	Consideration should be given to digitalise the “this is me” document and use it as a dementia passport document. Also, make it as a live document which could be further used for home care and nursing home settings	This is me is not a mandatory/Once for Wales NHS tool. There are numerous documents/versions of information that would identify a person needs etc. We shall discuss this and other documents at the next Dementia Board and suggest that Workstream 2a and Workstream 3 leads on this recommendation and determine the feasibility of adding this document to the newly developed patient information portal.	01/06/2023	31/01/2024	Overdue			30/06/2023

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Priority	Recommen-dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Proposed Revised Deadline	Due	If closed and not complete please provide justification and ensure evidence is available	Progress of work underway	Reporting Date
External	2017.00	Structured Assessment 2017	Not Rated	Director of Digital	High	R5	R5 The Health Board should ensure resources allocated to information technology and information management provide sufficient capacity to meet the Health Boards plans	A Strategic Outline Plan was developed for the Welsh Government in October 2016, which asked for a cost analysis to implement the Welsh Government E-Health and Care Strategy to assess the potential resource implications for Wales. The Health Board is currently revisiting the Strategic Outline Plan and Strategy in the light of the financial context and has also developed a new IMTP for Digital with ten priority areas linked to this Plan. The Health Board has undertaken a review and benchmarking exercise in order to develop a sustainability business case which recognises the need for further investment in core services. This has been discussed at a pre-investment panel and also shared at Board. It is being progressed as part of the IMTP of 2018-19	31/03/2019		Completed	10/08/23 Propose to close	Aug-23: This will be put into mth 4 Propose to close May 2023: proposal presented to Nicola, Awaiting final approval to action budget setting in month three. March 2023: Budget setting for 2023/2024 is underway. January 2023: No further update for this quarter. September 2022: ABUHB is contributing to a national benchmarking exercise including finance, human resources, and digital maturity. Locally formal budget setting has taken place. The Digital Delivery Oversight Board will take account of reources in quarterly meetings where significant initiatives are prioritised and agreed when the Target Operating Framework enables strctured reviews of new requests and the PMO will support in terms of resource allocation.	30/06/2023
External	2018.01	Structured Assessment 2018	Not Rated	Director of Corporate Governance	High	R1	R1 The Health Board should: ensure board member induction and training meets the needs of Independent Members.	The Health Board has already introduced a new Induction and training programme for 2018/2019. Several elements of this have been completed. The programme will be completed during 2019. The Health Board is also participating in the redesign of the national NHS Wales Induction Programme	31/12/2019	31/03/2023	Completed		Induction Process established (local and national)	30/06/2023
External	2018.01	Structured Assessment 2018	Not Rated	Director of Digital	High	R4	R4 The Health Board should address areas for improvement in relation to informatics, specifically updating ICT disaster recovery plans and test these to ensure they worked as intended.	key appointments have now been made against a number of positions relating to cyber security. Work is being completed on key personnel polices plans and underlying services. Work is ongoing with the newly recruited team in compliance with NISD. A Task and Finish group is currently prioritising and planning continuity arrangements led by the Emergency Planning Team.	31/03/2020		Completed	07/03/23 Propose to close	Aug 2023: Propose to close May 2023 - The current training compliance is 79%. The new training package from DHCW has still not been launched. Annual reports are being written for each of the Divisions highlighting areas where improvements to their training compliance is required. March 2023 -The current training compliance is 78% for the organisation. there will be a major communication exercise undertaken by IG commencing in April with the focus on getting an improvement in the compliance rate. Hopefully by then the new national training package will be made available by DHCW. January 2023 - First Governance and Assurance Board held and will be reporting into the Office of the SIRO. The Health Records module has been provided to the All Wales e-learning for	30/06/2023

Internal	2018.02	IT Service Management, May 2018	Limited	Director of Digital	High	R3	R3 Informatics should seek to develop a SKMS in order to share knowledge across departments. This process should include developing a Knowledge Centred Service (KCS) process within the service desks and ensuring models for calls and problems are catalogued and indexed and easily available.	Accepted; We recognise that this is a priority and that Service Point does not meet the needs of the service to develop the KCS (also identified by this audit) and therefore, Informatics will undertake a scoping and options appraisal exercise to define the requirements, including the resource needed.A business case has been developed for ICT only that seeks to address the concernswithin ICT; this work will inform the requirements of a similar review for Informatics.	31/10/2018		Completed	24/11/22 - The remainder of the activity now is sat with DHCW and therefore for AB Audit we propose this is monitored via DDOB and closed.	Aug-23 ABUHB have procured and implemented Halo ITSM as a replacement for Service Point within Informatics and are currently live with Incident Management, Request Fulfillment, Change and Problem Management, Knowledge And Config Management. A new self service user portal (Seren) has also been introduced) May 2023 - National programme has restarted with further development of business case to be completed in the near future. Locally we are well into the implementation of replacement ITSM system working alongside the supplier. Go live will be mid June following completion of build, user acceptance testing and training of staff. March 2023 - National Programme still appears stalled. Funding has been secured for local solution to replace service point for	30/06/2023
Internal	2019.00	Pay Incentives (2019/20)	Limited	Chief Operating Officer	High	R2	R2 In relation to the non-automated process only, consultants should submit signed claim forms for all additional sessions they are claiming payment for, listing appropriate details in respect of session dates, start/ finish times etc. and including a declaration that all sessions claimed are in addition to contracted work. The submitted claim form should be reviewed, validated and checked for accuracy before any payment is made.	Agreed. Executive Team will agree the approved system for claiming for all additional sessions and communicate with the Health Board. This must simplify the process for claiming to maximise compliance.	30/09/2019	30/04/2023	Completed		"Aug 2023: e-system should largely address these issues. The feedback provided was: There are only three categories of additional work and means of paying additional sessions 1. Temporary sessions in the job plan – currently via change form to pay roll. When we implement the new system we hope to work with Pay roll and the provider to have a more automated process e.g. as minimum changes in JP via report to payroll rather than need for change form. This will need to be discussed and worked up once we can engage with the company. The only validation around this would be in respect of achievement of outcomes. 2. WLI sessions – these are not part of job plan. Paid via form to payroll or excel sheet within the divisions. Should be validated within the division as per WLI policy. 3. Bank/locum – either via Patchwork or ADH form to	30/06/2023

Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R2	R2 A register of compliance requirements for all IM&T related legislation and standards across the whole organisation should be developed for the IGC along with a process for assessing status and reporting upwards to Committee.	Agreed. Currently the establishment, processes and mandate of informatics in ABUHB does not extend (with the exception of IG) beyond the directorate. In terms of accountability where devolved responsibility exists for information assets the same level of scrutiny and compliance should be applied. A corporate risk will be submitted with the recommendation of a strategic options appraisal for Board consideration and within this the role of Informatics as a Directorate will be considered along with other corporate and clinical divisions.	31/12/2021		Completed	March 2023 propose to close under Informatics Directorate as responsibility will sit with Rani	Aug-23: Policies reviewed by Templar and currently going through the approval process. Currently with the new Director of Digital to review. May 2023 - All policies are to be reviewed by the SIRO / DPO. March 2023 - The suite of 18 policies will be discussed at the inaugural meeting of the Office of the SIRO in May. Clarification of ownership is required so sign off can be completed. Templar are providing an elearning Cyber package for all staff in the organiosation to complete. January 2023- Revised and new policies completed and ready for sign off by the new SIRO which can then be disseminated through the GAGS and on the intranet. Identification of Senior Information Asset Owners and Information Asset Owners is the next stage and accountability to be assigned. August 2022 - New suite of 18 policies currently being	30/06/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R3	R3 Management should consider enhancing the risk management process in place within the Health Board by providing an annual report that identifies risks that have a low likelihood, have a severe worst-case scenario. This would ensure that executives are aware of the risks and worst cases that are being managed at a lower level, but hold the potential for severe adverse effects should they materialise.	Accepted. Part of the new governance will focus on the objectives of the CDO as SIRO for the Health Board. Following the review and adoption of the Target Operating Framework and HB exec oversight a programme will commence to adopt new policies, training and performance management of ICT and Information Asset including training for Information Asset Owners.	31/03/2022		Completed	Mar 23 propose to close under Informatics Directorate as responsibility will sit with Rani	Aug 2023: Propose to close. May 2023 - This will now be the responsibility of the Director of Corporate Services. March 2023 -: Inaugral meeting of the Office of the SIRO scheduled to take place May 2023 January 2023 - Agreement for Rani Mallison to take on the role of SIRO, Training completed. New policies awaiting her review and identification of the SIAO and IAO roles in order to provide training. Update to Board being provided by Rani September 2022 - SIRO training has been completed for the new SIRO and the first Office of the SIRO meeting is being arranged. August 2022 - SIRO training scheduled for September and HBOTS to be established. Initial discussions re the reporting structure for risk into the HBOT through the newly established Governance & Assurance Board June 2022 - programme has	30/06/2023

Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R10	R10 The Informatics Directorate budget should be set to reflect the actual need of the organisation. Where funding cannot be fully granted, the impact on the underfunded position of Informatics work and Digital Strategy delivery should be clearly stated and agreed with Executives.	Agreed. The Portfolio approach and executive oversight governance will provide the framework in which difficult prioritisation decisions must be taken to avoid historical best endevours approaches. Part of the recommendations from the review of informatics in ABUHB is to establish a dedicated Digital Investment Panel which will provide performance management and oversight to investments in digital. The Health Board recognises the need to prioritise and invest in order to deliver benefits and supports the principle of a benefits management realisation framework and strategy. Budget setting is taking place for next financial year with the aim to agree a growth commensurate with strategic objectives. The Target Operating model is designed to ensure capacity and capability of Informatics is fit for purpose and is currently being costed to inform a case for consideration.	01/10/2021		Completed	10/08/23 Propose to close	Aug 2023: Propose to close. May 2023 - Budget seting now reviewed and budget increased to reflect previous years spend March 2023 - DDOB cancelled for Q4. Director of Digital has been appointed and a review of the Digital Delivery Oversight Board will take place once they are in post January 2023 - DDOB cancelled for Q3. IMTP Planning underway which will result in a financial appraisal going forward. September 2022 -. Budget setting has been completed. DDOB now will consider resources for significant initiatives on a quartlerly basis. August 2022 - Singificant work undertaken during the last quarter on budget setting and realignment of cost centres providing high level of confidence and clearly defined areas that still require investment. June 2022 - yet to be realised - to be discussed at Digital	30/06/2023
Internal	2020.00	High Voltage Electrical System Management (2020/21)	Reasonable	Chief Operating Officer	Low	R4	R4 a)Operational Procedure and Operations & Maintenance files should be reviewed, with out of date documents archived and current documents filed, as required by HTM 06-03.b)Site/substation log books should be maintained in the format required by HTM 06-01 (section 8).c)Records of inspections / replacement of equipment for which the UHB is responsible for should be maintained in the HV	Agreed, we recognise the benefits of improved record keeping, to make current documents more accessible.	30/06/2021	06/10/2022	Completed		70%	30/06/2023
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R12	R12 Once the team has been re-established, the key security tasks should be in place:•regular review of firewall rules;•regular vulnerability testing; and•development of a security incident response plan.	Accepted. Active recruitment has been taking place with a Cyber Security Team leader successfully recruited. Emergency Planning colleagues have been collaborating with the cyber teamand the Health Board has contracted with specialist consultancy to accelerate the development of a Information Risk and Cyber Security operating model. Work will commence Q1 including cyber resilience and response plans.	31/12/2021		Completed	Januray 2023 - Propose Closure	Jan 23: Monthly reporting of KPIs to SIRO and Deputy SIRO once in place- Office of SIRO to be estblished but reporting to DDOB has been established January 2023 - Monthly reporting of KPIs to SIRO and Deputy SIRO once in place- Office of SIRO to be estblished but reporting to DDOB has been established. September 2022 -. Reporting continues and will support the induction of the new SIRO. Aug 22: KPI's monthly and will be reported at the October meeting with the new SIRO. June 2022 - now producing KPIs and reporting to Digital Delivery oversight Board (DDOB), established programme of work with Templar, which is led by the SIRO May 2022 - contract awarded to consultancy Mar 2022 to implement recommendations - Office of the SIRO / delegated letters of authority to all information asset owners.	30/06/2023

Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R12	R12 Once the team has been re-established, the key security tasks should be in place:•regular review of firewall rules;•regular vulnerability testing; and•development of a security incident response plan.	Accepted. Active recruitment has been taking place with a Cyber Security Team leader successfully recruited. Emergency Planning colleagues have been collaborating with the cyber teamand the Health Board has contracted with specialist consultancy to accelerate the development of a Information Risk and Cyber Security operating model. Work will commence Q1 including cyber resilience and response plans.	31/12/2021		Completed	Jan 23 Propose Closure.	May 23: work to commence shortly under SIRO Mar 23: Part of work programme that will be commencing from May under Rani Jan 23: Part of Cyber Resilience Programme- SIAOs in the process of being identified by new SIRO supported by Informatics- SIAOs will be trained and each will be accountable to identify assets within each division and directorate. Sept 22. SIRO training completed and new plan to be agreed in first Office of SIRO meeting. Aug 22: SIRO training scheduled in September and letters of delegatioN to be issued thereafter to the identified Senior Information Asset Owners Jun-22: Cyber Resilience programme commenced May 2022: contract awarded to consultancy Mar 2022 to implement recommendations - Office of the SIRO /	30/06/2023
Internal	2021.00	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory Report)*	Not Rated	Director of Corporate Governance	N/A	R3	R3 The Health Board should clearly document reporting requirements within its governance structures and plans, at each level of the organisation. This should include:i.expected frequency of reporting;ii.level of detail / assurances expected;iii.type of reporting expected, for example, tracking progress, reporting by exception, monitoring key metrics or performance indicators (KPIs), etc;iv.nature of the reports expected, for example, verbal, formal, set template, etc;	Not included within advisory report	31/12/2021		Completed		Accountability & Deployment Framework Included as a governance priority within the IMTP 2022-25 August 2023 - This action will be completed as and when structures are reviewed. It would not be possible to complete this without dedicated resource to review governance of all groups and meetings at every level of the	30/06/2023
Internal	2021.00	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory*	Not Rated	Director of Corporate Governance	N/A	R1	R1 The Health Board should ensure it clearly documents roles and responsibilities in its governance structures and plans.	Not included within advisory report	31/12/2021	31/03/2023	Completed		Accountability & Deployment Framework Included as a governance priority within the IMTP 2022-25 August 2023 - Achieved through respective policies,	30/06/2023
External	2021.05	Structured Assessment 2021	Not Rated	Director of Corporate Governance	High	R3	R3 Recent staff turnover within the Corporate Governance Support Team has impacted on the quality of service it is able to provide to the Board and its Committees. The Health Board, therefore, should review the effectiveness of its Corporate Governance Support Team as soon as possible to ensure that it has sufficient resilience and capacity to support all governance functions. Arrangements should also be put in place to ensure staff are able to access suitable training / learning opportunities to develop their knowledge and skills within their respective roles.	The Health Board accepts this recommendation. The Health Board will undertake a review and endeavour to ensure adequate and appropriate corporate governance capacity to fulfil the statutory functions of the Board and the Committees, enabling it to discharge its functions. It should be noted that external training in specific corporate governance, information governance and accredited risk management has been undertaken over the last two years, despite the pressures of the pandemic. This demonstrates the Health Board's commitment to develop and enhance skills within its governance team. However, it is also recognised that further mentorship and training programmes could be developed in order to 'future proof' the department and provide a robust corporate	30/09/2022	31/05/2023	Completed		August 2023: Organisational Change Process implemented. All roles expected to be filled November 2023. Mar 23 - Consultation process currently underway for a re-strcuture of the corproate governance team. This will enable the recommendation to be implemented. ARAC to be updated with final outcomes as soon as they become available. Request revised deadline date of 31st May 2023	30/06/2023

External	2021.05	Structured Assessment 2021	Not Rated	Director of Corporate Governance	High	R4	R4 The Health Board has experienced significant changes in its Executive Team and cadre of Independent Members resulting in several interim Executive Director appointments and is currently recruiting to two independent member vacancies. However, maintaining these temporary arrangements indefinitely alongside the turnover of Independent Members present risks at a time of significant operational pressures. The Health Board, therefore, should seek to make Permanent appointments to these key Executive Director roles at the earliest possible opportunity. In addition, there remains a need for the Health Board to strengthen its induction and training for new Independent Members in line with our recommendation in 2019	The Health Board accepts this recommendation. Independent Members Interviews have now been undertaken for Independent Members for Finance and Digital and the recruitment process for this continues to progress. Continued liaison with the Public Appointments Team to progress the substantive recruitment of the Vice Chair and an Independent Member for Community is anticipated to progress from February 2022. Executive Team: Chief Executive Officer (CEO) – interim arrangement to be continued during 2022. Director of Primary Care, Community & Mental Health –recruitment in process. Director of Finance & Procurement – interim appointment to be extended in line with Interim CEO arrangement. Deputy CEO – interim appointment to be continued in line with Interim CEO arrangement. Interim Director of Operations – current interim appointment until April 2022. Recruitment process to commence shortly.	30/04/2022	31/03/2023	Completed		August 2023: Induction Process established (local and national). Board member vacancies now appointed to. Board Member Induction Included as a governance priority within the IMTP 2022-25. Board Member vacancies progressing with most now appointed to.	30/06/2023
External	2021.05	Structured Assessment 2021	Not Rated	Chief Executive	N/A	R1	R1 The Health Board's website contains some outdated information relating to its governance arrangements and incomplete performance data which is not supported by appropriate explanatory information. The Health Board, therefore, should take immediate action to ensure: *Content is wellorganised, easy to navigate, clear and concise, and • Key information / data is up-to-date and in a format that the public and stakeholders can interpret and understand.	The Health Board accepts this recommendation. The website is in the process of being reviewed and updated to reflect suggestions made including, ensuring all fundamental Health Board information (related to Board, Committees, and governance arrangements) is accurate and up to date for the public and stakeholders. Further developmental work will be required to ensure Divisional engagement around local pages on the website arekept up to date with useful and meaningful information. However, it should be acknowledged that the resource required in order to conduct such a substantial review is not inconsequential.	31/03/2023		Completed		Aug 2023: The Health Board's website has been reviewed, and all necessary changes have been made to ensure that the information is current and up to date. The website will be monitored and updated with any changes	30/06/2023
External	2021.06	Quality Governance Review	Not Rated	Director of Workforce & OD	N/A	R3	R3The Health Board has a well-established values and behaviours framework which sets out its vision for a quality and patient safety focussed culture. However, there is a mixed picture in relation to the culture around reporting errors, near misses or incidents and raising concerns and the action taken by the Health Board to address them. The Health Board should undertake work to understand why some staff feel:•they are not treated fairly orgiven feedback when reportingerrors, near misses orincidents. that the Health Board does notact on concerns they raise ortake action to minimise futureoccurrence of errors, nearmisses or incidents	The ABUHB Value Framework has been refreshed recently. There is clearly a need to remind managers and leaders to ensure feedback to staff who have raised concerns and this will be reinforced through Divisional Triumvirates for cascade. A review of concerns raised by staff and the actions taken will be conducted to provide assurance.	31/10/2022	31/05/2023	Completed		Aug 23 We have introduced a central Raising Concerns email for all staff to raise concerns where they feel they cannot raise these with line managers or via the HR Helpdesk. For all staff who raise concern via this method or via the Respect and Resolution Policy, they will be provided with a detailed response/outcome. Mar 23 Collaboration with departments has explored the Datix reporting mechanisms to understand the feeling around this process and how we can better support managers to feedback learning and outcomes. Finally, we are beginning to design the core skills training programs across the Health Board in a host of areas such as difficult conversations, giving and receiving feedback and others related to this issue which will support staff to take action.	30/06/2023

Internal	2021.13	Continuing Healthcare MH&LD	Limited	Chief Operating Officer	High	R1	R 1.1 The Division should further strengthen performance reporting, with a heightened focus on QPS metrics (akin to the processes embedded with the Complex Care Division: general adults). 1.2 The Division should explore interim options to automate and streamline the existing databases until the introduction of WCCIS, and ensure the databases are up to date. 1.3 The Division should improve the reporting arrangements of commissioned services ensuring Executive sightedness together with Patient Quality, Safety & Outcomes Committee. 1.4 The Divisional Risk Register should be updated to include the risk associated with the backlog of auditing.	1.1 The Performance report will be strengthened to include PQS metrics. 1.2 The utilisation of the databases will be reviewed with an interim plan developed to reduce duplication and ensure completeness. 1.3 A quarterly performance report will be produced and discussed at Divisional level and the Executive Assurance meeting, together with inclusion in the PQSOC Performance Report as per the business cycle.1.4 The Divisional Risk register will be updated to include the risks associated with the auditing backlog.	30/06/2022	30/06/2023	Completed		Nov 2022 - first performance report to be presented on 25th November 2022 to CHC Divsional assurance meeting. Remains in progress at this stage. Process supported by SIM who is now in post. WCCIS is now operational however, there have been challenges in implementation. A plan to develop organisational assurance mapping linked to internal control systems has been agreed between the Head of Risk and Assurance and the Directorate. A deadline of April 2023 is being actively worked towards.	30/06/2023
Internal	2021.13	Continuing Healthcare MH&LD	Limited	Chief Operating Officer	Medium	R2	R2.1 Clarity should be provided in terms of the roles and responsibilities of the Commissioning Team and the Care Coordinators, particularly associated with annual reviews.	2.1 The respective roles and responsibilities of the Commissioning Team members and Care Coordinators will be reinforced, ensuring clarity.	31/03/2022		Completed		June 2023 - 'Role of Care Coordinators and Case Managers' document completed with input from Directorate Managers; Chris Jones attending Mental Health Ward Managers meeting 06.06.23 to discuss. Joe Edwards, Commissioning Practice Educator in post and will include this as part of training package from July 2023. Nov 2022 - 2.1 'Role of Care Coordinator and Case Managers' document produced for review. To be finalised by end of September 2022	30/06/2023
Internal	2021.24	Flow Centre	Reasonable	Chief Operating Officer	Medium	R5	R5 The Flow Centre Team should provide assurance to an appropriate committee or group of the delivery of the expected benefits.	The Flow Centre has been operational for a period of time that will enable an effective review of the service projected benefits and assurance to the objectives given. With recent changes in clinical and operational leadership of the Flow Centre a focus will be to review the service by the target date	30/10/2022	31/07/2023	Completed		Mar 23 •The flow centre feeds into Urgent Care SMT and DMT governance structures as well as weekly SLR operational oversight.	30/06/2023
Internal	2022.02	Job Evaluation Process	Reasonable	Director of Workforce & OD	Low	R2	The Health Board should review, update if applicable,and ratify the Banding of New Posts policy. Once this has been completed,theHealth Board should ensure all related policies / procedures have been updated and linked correctly on the intranet page.	Recommendation accepted. Work has commenced to update the Banding of New Posts Policy inpartnership with staff side lead,ensuring alignment with any recent JEG recommendations. First draft to be submitted to the Workforce & OD Policy Group in December 2022	31/03/2023		Completed		Aug 2023: Policies agreed and published January 23. New intranet site established linking guidance and policies	30/06/2023
Internal	2022.06	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	N/A	R8	Potential collaboration and common utilisation of decarbonisation resource should be considered on an All-Wales basis, particularly in relation to consultancy advice and training resource.	Agree. ABUHB & PTHB are currently collaborating on Biodiversity Assessments funded through HSC Climate Emergency Fund.	31/03/2023		Completed			30/06/2023
Internal	2022.10	Newport HWB Centre	Reasonable	Chief Operating Officer	Low	R1	R1 The Project Execution Plan should be updated to reflect current governance arrangements	Agreed. The PEP will be updated.	31/01/2023		Completed		Aug 2023: The PEP is regularly being updated to reflect chaning circumstances, a further update will be taken to the PB on 17th October reflecting changes to internal governance	30/06/2023
Internal	2022.10	Newport HWB Centre	Reasonable	Chief Operating Officer	Low	R5	R5 A standard and consistent range of project reports should be submitted to the Primary Care & Community Estates Programme Board, to support the 'project board' role and responsibilities of the forum (to be defined as per recommendation 2.1).	Agreed. Improved reporting has been implemented at other projects and will be introduced at Newport going forward.	01/01/2023		Completed		Aug 2023: Reports were provided to the old Programme Board but that has not met since April 2023. They are provided to the Project Team and WG.Remit of the Capital Planning Team	30/06/2023

Internal	2022.10	Newport HWB Centre	Reasonable	Chief Operating Officer	Low	R6	R6 Project Team meetings should be supported by a standard agenda, including submission of a Low standard and consistent range of project reports. This should include the Cost Report and external PM's progress report for information (albeit recognising the full detail of these technical reports may not be reviewed during the meetings).	Agreed. Improved reporting has been implemented at other projects and will be introduced at Newport going forward.	01/01/2023		Completed		Aug 2023: Reports are routinely provided to the Project Team. Remit of the Capital Planning Team	30/06/2023
Internal	2022.10	Newport HWB Centre	Reasonable	Chief Operating Officer	Medium	R10	R10 Project Control Forms should be authorised in accordance with the Standing Orders (Scheme of Delegation).	Ongoing throughout project.	01/03/2023		Completed		Aug 2023: This is an ongoing action. All PCFs currently comply with the Scheme of Delegation	30/06/2023
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Medium	R8	The requirements for security should be included in development guideline and procedure documentation in preparation for transition to a service.	Agreed. Cyber security and service management arrangements will be reviewed following a successful case to executive colleagues.	01/06/2023		Completed		Aug-23: This recommendation can be closed. All robots are set up in an identical way and have been assured by our Cyber Resilience team. Data Privacy Impact Assessments are undertaken on the basis of assessed need in relation to Person Identifiable Information and any new Robots follow the Change Process to ensure all assurance activities are completed.	30/06/2023
Internal	2022.16	Financial Sustainability	Reasonable	Director of Finance and Procurement	Medium	R2	Savings plans should be set with clear ownership (e.g. appropriate / senior individual) and SMART objectives (where appropriate). A more formal process should be developed to ensure this	Accepted. The revised accountability framework will provide greater management focus on savings delivery. Whilst the IMTP identifies the savings plans at a divisional level for 2023/24 and current FCPs already identify the need to operate within delegated budgets, we will ensure objectives are appropriate	01/05/2023		Completed			30/06/2023
Internal	2022.16	Financial Sustainability	Reasonable	Director of Finance and Procurement	Medium	R2	Where a budget has not been achieved, clear actions should be set, with a responsible owner to implement them. Formal action plans should be developed where savings plans fall behind on delivery. Summary of these action plans and related progress updates should be formally reported to the Finance and Performance Committee (e.g. as part of the MI packs). Assurance should be provided to the Finance and Performance Committee and the Board that plans are in place to turn around poor performing savings plans.	More detailed reporting to the Board and F&PC on mitigation plans will be considered as part of the accountability framework, but should be the responsibility of the relevant budget holder. The newly proposed Financial Improvement & Efficiency Board will support this	01/05/2023		Completed		Parts 1 and 2 have been completed. 3 remains overdue	30/06/2023
Internal	2022.16	Financial Sustainability	Reasonable	Director of Finance and Procurement	Medium	R1	The budget delegation letters should be completed as soon as possible after the start of the financial year.	Accepted. We will ensure the delegation letters are completed as soon as possible after the start of the financial year	01/04/2023		Completed		Aug 2023: Ones NOT returned are: James Calvert Peter Carr (He has a meeting with Finance on 23/8 to discuss) Tracy Daszkiewicz Hannah Evans (been on leave for 2 weeks) Sarah Simmonds (on leave)	30/06/2023
Internal	2022.16	Financial Sustainability	Reasonable	Director of Finance and Procurement	Medium	R1	Delegation letters should be formally reissued when significant changes are made to the budget.	Accepted. The value / definition of 'significant' will be considered and letters formally reissued if this threshold is met	01/05/2023		Completed			30/06/2023
Internal	2022.17	Risk Management	Reasonable	Chief Operating Officer	Medium	R1	The Complex and Long Term Care Division should monitor and assess the risk register at the Divisional Management Team meetings and ensure that the risk mitigation actions still remain appropriate. Consequently, any risks that requiring updating / removal should be formally discussed and agreed upon at each Divisional Management Team meeting	Agreed. The Complex and Long Term Care Division will monitor and assess the risk register and make necessary amendments at the Divisional Management Team meetings.	01/04/2023		Completed		Complete.	30/06/2023
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	Medium	R2	The key Heath Board roles and responsibilities i.e. Senior Responsible Officer, Project Director, Project Manager, Estates lead, and Head of Capital Planning etc., should be fully defined and approved by the Project Board.	Agreed. The Project Execution Plan is to be updated to reflect the recommendation.	01/06/2023		Completed		Aug 2023: The PEP is regularly being updated to reflect chaning circumstances, a further update will be taken to the PB on 28th August reflecting changes to internal governance	30/06/2023

Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	Medium	R2	Operation and membership of the commercial, technical and progress meetings should be defined at the Project Execution Plan to include: (a) the requirement to minute meetings; (b) define Health Board officer membership, and (c) interaction with other key project groups e.g. the project team.	Agreed. The Project Execution Plan is to be updated to reflect the recommendation.	01/06/2023		Completed		Aug 2023: The PEP is regularly being updated to reflect chaning circumstances, a further update will be taken to the PB on 28th August reflecting changes to internal governance	30/06/2023
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	High	R3	Risk monitoring should include: • quantification of all known risks (best, worst, likely case scenarios) where possible; • the quantified total of mitigated risks reported against remaining contingency; • risk costs, risk owners (named individuals), and time parameters for risk mitigations at risk registers; • an exception report of targeted risk mitigations not achieved; and • corresponding numbering / referencing of common risks at project management, and contractual versions of the register.	Agreed noting that the service and capital risk registers are quite different in context and content, the former will be addressed via the Project Team, the latter via the Commercial Meeting and the external Project Manager.	01/06/2023		Completed		Aug 2023: Risk Registers continue to be updated for both service and capital risks	30/06/2023
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	Medium	R5	Management should review the Project Progress Return submissions to Welsh Government to ensure accuracy	Agreed and already actioned.	01/06/2023		Completed		Aug 2023: PPRs have been reviewed and continue to submitted to WG	30/06/2023
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	Medium	R5	Agreed. The Cost Adviser has been requested to provide a summary report as are available on other projects	Agreed. The Cost Adviser has been requested to provide a summary report as are available on other projects	01/06/2023		Completed		Aug 2023: An Exec Summary is provided via the cost reports	30/06/2023
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	Low	R8	Records of site inspections and audits should be presented to project forums for appropriate scrutiny and action.	Agreed. The appropriate forum, the monthly Progress Meeting, will receive these records in future, for escalation as appropriate.	01/06/2023		Completed		Aug 2023: The monthly Progress meeting receives updates on various inspections. Reporst themselves are reviewed by the Project Supervisor	30/06/2023
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	Medium	R9	The Health Board will ensure compliance with the Health Board's Scheme of Delegation (at the management of all Compensation Events) and any issues of non-compliance reported to an appropriate forum.	Agreed. Change control procedures have been reviewed, updated and actioned. This Audit report will also be taken to the next Programme Board where this issue will be highlighted.	01/06/2023		Completed		Aug 2023: The Audit Report, which identified issues of non-compliance, was taken to the April Programme Board. There has not been any further issues with compliance. The Audit Report has also been discussed with the Project Team at a meeting of the Audit C'tee.	30/06/2023
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	Medium	R9	Change control procedures should be reviewed and updated to ensure consistency (i.e. between the NEC form of Contract, Health Board Standing Orders/Standing Financial Instructions and the Project Execution Plan).	Agreed, Change control procedures have been reviewed, updated and actioned.	01/06/2023		Completed		Aug 2023: Change Control Procedures have been updated	30/06/2023
Internal	2022.20	Tredegar Health & Wellbeing Centre Final Internal Audit Report	Limited	Chief Operating Officer	High	R10	Single Tender Quotation / Requests should be approved in accordance with Standing Orders / Standing Financial Instructions	Agreed. Non-compliance to be advised to the Programme Board via submission of this audit report and the Director of Finance.	01/06/2023		Completed		Aug 2023: The Audit Report, which identified issues of non-compliance, was taken to the April Programme Board. There has not been any further issues with compliance. The Audit Report has also been discussed with the Project Team at a meeting of the Audit C'tee.	30/06/2023
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Low	R1	The Project Execution Plan should be updated to reflect current governance arrangements.	Agreed, the PEP has been reviewed & updated for sign off by the May Project Board	01/06/2023		Completed		Aug 2023: The PEP is regularly being updated to reflect chaning circumstances, a further update will be taken to the PB on 21st September reflecting changes to internal governance	30/06/2023
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Low	R2	Terms of Reference will be enhanced to ensure adequate governance arrangements are applied.	Agreed, the Terms of Reference and membership of both the Project Team and Project Board were agreed in December 2022 but are currently being reviewed by VUNHST due to internal management changes. It is intended to obtain sign off at the May Project Board. This will include quorate and frequency.	01/06/2023		Completed		Aug 2023: There have been several versions of the Terms of Reference of both the PB and PT due, primarily, to changing circumstances within Velindre. A final version of the PB ToR was submitted to the	30/06/2023

Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R2	Members of the respective Meeting groups should be reminded of the need to regularly attend meetings.	Agreed, to be addressed as part of the above	01/06/2023		Completed		Aug 2023: This is an ogoing action	30/06/2023
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	High	R4	The Project Board will retrospectively scrutinise the tender report to affirm that value for money has been attained at the agreed Target Cost	Agreed, the Tender report will be submitted to the May Project Board. It should be noted however that detailed discussion took place between the Health Board, it's Cost Advisors and NHS Shared Services as part of the scrutiny process and a request was made by WG to agree a Target Cost prior to FBC approval. The process was further complicated by the appointment of the Linac Supplier by VUNHST after the FBC was submitted. This resulted in a further adjustment of the capital costs, via the inclusion of PC sums, prior to FBC and Target Cost approval.	01/06/2023		Completed		Aug 2023: The Tender report was retrospectively submitted to the May PB	30/06/2023
Internal	2022.22	RGH Redevelopment & Expansion of Endoscopy Services	Reasonable	Director of Strategy, Planning & Partnerships	Low	R1	The PEP should be regularly reviewed and updated to reflect the appropriate stage of the project's lifecycle	The PEP is being reviewed & updated for sign off by the Programme Board.	01/06/2023		Completed		Aug 2023: The PEP is regularly being updated to reflect chaning circumstances, a further update will be taken to the PB on 21st September reflecting changes to internal governance	30/06/2023
Internal	2022.22	RGH Redevelopment & Expansion of Endoscopy Services	Reasonable	Director of Strategy, Planning & Partnerships	Low	R2	Project team terms of reference should be reviewed for appropriateness and updated accordingly	Terms of Reference of the Project Team and membership are being reviewed for the agreement of the Programme Board	01/05/2023		Completed		Aug 2023: ToR for the PT were submitted to the May PB	30/06/2023
Internal	2022.22	RGH Redevelopment & Expansion of Endoscopy Services	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R2	Attendance of key project members at meetings should be monitored, with action taken where issues are identified	Review of attendance at meetings on an ongoing basis.	01/05/2023		Completed		Aug 2023: This an ongoing action	30/06/2023
Internal	2022.22	RGH Redevelopment & Expansion of Endoscopy Services	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R4	The full outturn cost position (including equipment and net VAT positions) should be incorporated within the routine financial reports to both the project team and project board.	VAT will form part of the reporting within the Cost Accountant Finance Report.	01/06/2023		Completed		Aug 2023: Action complete - VAT included on cost report.	30/06/2023
Internal	2022.22	RGH Redevelopment & Expansion of Endoscopy Services	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R4	The Welsh Government dashboard reports should be submitted to the project board for review, prior to submission	Welsh Government dashboard report to be reported at Project Board	01/06/2023		Completed		Aug 2023: Action complete - PPR templates included in the papers for Project Team & Programme Board.	30/06/2023
Internal	2022.22	RGH Redevelopment & Expansion of Endoscopy Services	Reasonable	Director of Strategy, Planning & Partnerships	High	R8	The UHB should ensure all contracts operating at this project are appropriately executed.	All Contracts associated with the project are being reviewed for appropriate Execution	01/05/2023		Completed		Aug 2023: All contracts have been appropriately executued .	30/06/2023
Internal	2022.22	RGH Redevelopment & Expansion of Endoscopy Services	Reasonable	Director of Strategy, Planning & Partnerships	Low	R9	Change management arrangements should be confirmed and aligned with the UHB delegated limits.	The change management arrangements will be confirmed within the PEP.	01/06/2023		Completed		Aug 2023: The PEP is regularly being updated to reflect chaning circumstances, a further update will be taken to the PB on 21st September reflecting changes to internal governance	30/06/2023
Internal	2022.22	RGH Redevelopment & Expansion of Endoscopy Services	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R9	Appropriate evidence should be maintained by the cost adviser that justifies the costs associated with variations to the contract.	The cost adviser will be informed that appropriate evidence for variations must be maintained.	01/06/2023		Completed		Aug 2023: CA confirmed all evidence is scrutinised prior to sign off of variations. This incident occurred when the previous CA was in post	30/06/2023
Internal	2022.22	RGH Redevelopment & Expansion of Endoscopy Services	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R10	The UHB should ensure timely responses when receiving request for information.	Follow up RFI response and record appropriately.	01/05/2023		Completed		Aug 2023: RFI response is followed up and reported through register	30/06/2023
Internal	2022.22	RGH Redevelopment & Expansion of Endoscopy Services	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R10	Where targets are missed, appropriately commentary should be maintained, and updated timescales agreed.	Review RFI Schedules and update and report accordingly.	01/05/2023		Completed		Aug 2023: RFI register is reviewed and updated in line with monthly progress meetings.	30/06/2023

External	2021.01	Efficiency Review	Not Rated	Director of Finance and Procurement	N/A	R9	R9 By the end of January 2023, implement stronger approaches for monitoring the deployment/delivery of savings to better understand where service improvements are and aren't delivering the necessary efficiency and financial improvement. As part of this ensure there is timely and effective corrective action.	It is recognised there is a need to reconsider & develop a new approach to Savings agreement and ownership and management intervention, this will be developed as part of the revised governance approach for ABUHB, through the financial recovery plan actions.	31/03/2023		Completed		outstanding – revised accountability framework still in draft status (March Board 23) – however existing Budgetary control FCP still relevant as a financial accountability mechanism as	30/06/2023
External	2021.01	Efficiency Review	Not Rated	Director of Finance and Procurement	N/A	R8	R8 By March 2023, strengthen the use of visual management tools including service transformation trackers, saving trackers and linked risk trackers for all programmes. This performance information needs to be communicated to relevant service management for increased responsiveness.	The approach to more visual savings reporting will be alignedwith the response to R7 above and established as part of the financial recovery process and IMTP development.	31/03/2023		Completed		Savings reporting at divisional level will be given greater focus as part of financial reporting in 23/24 – aligned to IMTP.	30/06/2023

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Priority	Recommen-dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Proposed Revised Deadline	Due	If closed and not complete please provide	Progress of work underway	Reporting Date
External	2018.01	Structured Assessment 2018	Not Rated	Director of Digital	High	R3	R3 The Health Board should improve its information governance arrangements by: improving compliance with the information governance training programme to reach the national rate of 95%.	Information Governance training reviewed to include the legislation changes as a result of GDPR. An additional module was developed and launched for Cyber Security which is mandatory for all staff to complete. The Information Governance Unit has set up Information Governance Delivery Groups (IGDG) for each of the Divisions in the organisation. The meetings are held bi monthly and training is included on the agenda for every meeting. Discussions are held specifically around compliance and Managers are tasked with improving their compliance rates. Reports are assessed at Transformation to Digital (T2D) Delivery Board.	01/03/2020		Overdue		Aug-23: Training compliancis currently 84%. ABUHB now using new all Wales training package for DHCW which includes cyber security. Paul to pick up with Jon. May 2023 - The current training compliance is 79%. The new training package from DHCW has still not been launched. Annual reports are being written for each of the Divisions highlighting areas where improvements to their training compliance is required. March 2023 _ The current training compliance is 78% for the organisation. there will be a major communication exercise undertaken by IG commencing in April with the focus on getting an improvement in the compliance rate. Hopefully by then the new national training package will be made available by DHCW. January 2023 - First Governance and Assurance Board held and will be reporting into the Office of the SIRO. The Health Records module has been provided to the All Wales e-learning for incorporation into the new elearning launch. Final review is expected at the end of November. Monitoring will be improved as this will go into ESR and is now part of a national programme of work August 2023 - The Information Governance Unit have been engaged with national IG leads to create a new IG training programme into which ABUHB training has been amalgamated and can now be directly accessed through ESR. This will	30/06/2023
External	2021.01	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Workforce & OD	High	R1	The Health Board should review the arrangements in place toensure that annual leave for all staff is accurately recorded and held centrally	The introduction of Medical E-Systems will ensure that all leave is recorded. The Health Board have agreed to procure a suite of Medical E-Systems with roll out in April 2022. However, departments have started recording leave in Electronic Staff Record (ESR). Communications will be sent to Medical Leaders in December 2021 to ensure that leave is recorded onto ESR pending the introduction of full Medical E-Systems.	30/04/2022		Overdue		Aug 2023: The roll out the newly procured workforce medical e-system will resolve the logging of annual leave centrally. Incremental implementation will progress once purchased. Current technical issues with procurement. If resolved implementation will commence October 23. Nov 2022 the roll out the newly procured workforce medical e-system will resolve the logging of annual leave centrally. Incremental implementation will progress over the next 9	30/06/2023
External	2021.01	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Digital	Medium	R3	The HealthBoard should consider strengtheningtheirIT Controlsas follows:i.All of the Windows server 2008 operating system should be replaced with either or Windows 2012 or higher where possible (this is almost completed with only twenty three servers left). ii.W7 and W8.1 desktop devices should be replaced as these are now de-supported. iii.Ensure that the change management procedure is finalised.iv.The IT Data Recovery Plan and Backup Policy should be updated and clearly defined.v.With regards to the Wellsky system, leavers and accesses changes should beformally recorded, and the Health Board shoulddevelop a suite of audit and security reports to run and monitor to ensure user access is appropriate.	i.With regards to our Windows Server 2008 environment, we have an active programme of work to either upgrade or decommission these servers. It is envisaged that by the end of the current quarter only a few servers may remain, although weare currently investigating options for these.ii.ABUHB have made significant progress in removing Win7/8.1 from our estate and currently have 0.4% to complete.There is an active programme of work to remove these devices from the network or upgrade them toa supported version of Win10.iii.We have an established and robust Change Management Process in place with regularly scheduled and structured Change Advisory Board meetings to manage operational change.The process has been widely socialised with all of Informatics and other Key Stake Holders, and also engages effectively with other ITIL practices such as Incident Management and Asset/Configuration Management.Critical Success Factors and Key Performance Indicators are agreed and monitored to measure effectiveness.iv.The IT Data Recovery Plan and Backup Policy is still in the process of being reviewed and updated.A draft version has been shared within the team and the finalised version will be released within the coming weeks.v.All user accounts are processedin line with NHS Wales standards.There is a current risk that unless a	31/12/2021		Overdue		Aug-23: No update - older servers are being replaced via critical server refresh project, updated figures to be provided by SC May 23: No further update Mar-23: Discussion with 3rd party is still ongoing Jan-23 i. Currently there are 2 remaining servers left on 2008. These rely on upgrades to the software applications to enable the move to a supported Windows Server version. The team will continue to liaise with the services to remove the last 2 remaining. ii. Currently we have 3 devices remaining. The team will continue to liaise with the services to remove the last remaining. iii. Confirmed this was completed. iv. Confirmed this was completed.	30/06/2023

External	2021.04	Agile Delivery	Not Rated	Director of Workforce & OD	N/A	R6	R6 NHS bodies should seek to build on existing local and national workforce engagement arrangements to ensure staff have continued opportunities to highlight their needs and share their views, particularly on issues relating to recovering, restarting, and resetting services. NHS bodies should ensure these arrangements support meaningful engagement with underrepresented staff groups, such as ethnic minority staff.	The Health Board has initiated an innovative 12-month engagement programme called "#PeopleFirst, #CynnalCynefin, reconnecting our workforce". The origins are within the values of the Health Board and is a collaborative programme delivered by Wellbeing, OD and the Executive Board. The programme aims to re-connect staff to each other, to managers and senior leaders to empower them to raise and solve local problems locally, raise concerns to a higher level and offer the experience of feeling heard. As of December 2021, the project team have run 6 hospital site-based events, interacted with over 50 staff who have raised over 90 issues which we are working on. The project continues into the new year with cross-executive support.	31/12/2022		Overdue		June 2023: 1) As a quality assurance measure, an EQIA Group has been established to monitor EQIAs. 2) Screening tool has been developed and is being implemented	30/06/2023

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Priority	Recommen-dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Proposed Revised Deadline	Due	If closed and not complete please provide justification and	Progress of work underway	Reporting Date
External	2022.05	Structured Assessment 2022	Not Rated	Director of Nursing	N/A	R3	R3 There is limited use of patient and staff stories at Board. The Health Board should consider how it can increase and maximise the benefit of patient and staff stories in Board and committees to help centre and focus meetings on the things that matter most, and to help triangulate this intelligence with formal agenda items.	A Digital Story Protocol for staff and patient stories is currently under development and once approved an electronic digital repository of stories will be created. Digital Story Telling training has been commissioned. The CIVICA Citizen Feedback System now allows people to leave narrated stories. A selection of these will be played at the start of every Board meeting. The Executive Team will agree a programme of staff and patient stories that help triangulate intelligence with formal agenda items.	31/03/2023	31/12/2023	Overdue		June 23: A Patient Experience & Involvment Strategy has been developed which includes Digital Patient Narratives and Stories. A patient story has been presented at a Board Development Session and PQSOC this year. Update July 2023: The Digital Story Protocol is drfated but is now being revised due to recent decisions to support 'in-person' patient experiences at Board. To date, a patient story has been played at each Board during 2023. Additionally, digital stories are being used at listening and learning events and development days. There is all Wales discussion around a digital toolkit. The	30/06/2023

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Priority	Recommen-dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Proposed Revised Deadline	Due	If closed and not complete please provide	Progress of work underway	Reporting Date
Internal	2017.00	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies and Health Science	High	R1	R1 Registers should be maintained for operational management of medical devices and equipmenton each ward and department, which should record relevant equipment details.The register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed.Each areashould ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record itupon theirregister. Discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded. Going forward, relocation of equipment, disposals, additions etc. should be updated promptly to ensure an accurate record continues.	The Health Board to consider investing in an overarching equipment database register with staff resources to ensure regular updating and management.	31/03/2018	31/08/2023	Not Yet Due		November 2022 - This recomendation is monitored reguarly via the Medical Devices Committee. The deadline is proposed to be extended due to Health Board ability to get around all of the equipment. We would suggest that the system is in place to track the assests however, further work is required to phyiscally tag the equipment and ensure compliance and tracibility.	
External	2017.00	Structured Assessment 2017	Not Rated	Chief Executive	High	R7	R7 The Health Board should review, refresh and update the Engagement Strategy – 'Hearing and acting upon the voice of our staff and citizens'.	The Health Board will undertake a review and refresh its Citizen Engagement Strategy in line with the Clinical Futures Programme and IMTP. The Health Board will also continue to take forward its programme of staff engagement in line with the Clinical Futures Programme.	31/07/2018	30/09/2023	Not Yet Due		May 2023 - The Communication and Engagement Strategy will be presented to Board in September for approval.	
Internal	2021.05	Pathology	Reasonable	Chief Operating Officer	Low	R8	R8 The Health Board should complete a refresh of the latest workforce planning exercise(including associated laboratory space and equipment), to ensure the service requirements can still be met over the next five years and beyond.Where additional resourcing / facilities arerequired, theseshould be factored into the IMTP process.	To review and updateworkforce plans as appropriate. Workforce is factored into the IMTP	24/02/2022	01/09/2023	Not Yet Due		All managers were asked to review their workforce plans following the audit. The Cellular Pathology workforce plan is included in sustainability paper, JH has confirmed the paper will need to be re-reviewed if 7 day working is planned. Mortuary workforce plan in progress with follow up meeting 6 weeks from 27/9/22. Microbiology workforce plan in progress to be completed by 5/10/22. Blood Sciences workforce plan in progress to be reviewed 5/10/22 prior to completion. All additional workforce requirements are already factored into annual plan/IMTP.	
External	2021.06	Quality Governance Review	Not Rated	Director of Therapies and Health Science	N/A	R1	R1 Divisional risks are presented to Quality and Patient Safety Operational Group, but there was limited evidence of in-depth analysis and discussion. There is also limited evidence that the General Surgery directorate maintain risk registers that adequately identify quality and safety risks and mitigating actions. The Health Board should:•ensure there is appropriatescrutiny, challenge, cross divisional discussion and sharing of good practice around divisional risks at the Quality and Patient Safety Operational Group. •ensure that risk registers arecompleted and maintainedacross all directorates thatidentify quality and safety risksand mitigating actions andthere are appropriate riskescalation arrangements.	The form and functionof Quality Patient Safety Operational Group is currently being reviewed, with the aim of strengthening oversight of Risk. ABUHB are in the process of introducing the OFWCMS with the Risk module part of a future phase of roll-out. This will be a driver for improving Divisional ownership of risk management and mitigation. A programme of Divisional awareness raising will be introduced across ABUHB to strengthen risk management processes.The responsibility of Divisional Directors will be reinforced in terms of maintaining registers and ensuring appropriate mitigation.	31/10/2022	28/09/2023	Not Yet Due		This action is currently marked as overdue on the tracker, and I propose a revised deadline of end of September 2023. The justification for this revised deadline is related to the implementation of the HB's new Quality Strategy that was only agreed by the Board in March 2023, and because this Internal Audit recommendation has now been superseded by the development of the Quality Strategy. This action needs to align to the implementation of the Quality Strategy, which requires a full review of the QPS governance framework and the related committee / meeting structure and function, including the QPSOG. The role of the QPSOG in providing oversight and scrutiny of QPS related risk will be considered in that review, alongside other HB arrangements, such as Divisional Assurance meetings and Divisional level QPS Fora. It should not be assumed that the QPSOG will continue to fulfil this function as other arrangements may be more appropriate. To further support the implementation of the Quality Strategy, specifically strengthening oversight and scrutiny of risk, the application of risk modules within DATIX will be employed and this work is progressing well but is just an enabler to	

External	2021.06	Quality Governance Review	Not Rated	Director of Nursing	N/A	R6	R6 The Health Boards quality assurance framework includes a range of committees and groups aligned to Health and Care Standards. The framework is assisting the Health Board in identifying areas which previously had not provided assurance. However, there are still gaps in the flows of assurance from some sub-groups and in relation to elements of the Health and Care Standards. Whilst the framework is reasonably comprehensive at a corporate level, it doesn't fully articulate the operational structure and processes for quality and safety. The Health Board should:•complete its review of thequality and safety framework toensure that flows of assuranceare appropriate, and that the •framework functions asintended.•articulate the operationalstructures and processes forquality and safety within thequality assurance frameworkand how they align with thecorporate structure to provide a'floor to board' assurance.	The Quality Assurance Framework will be reviewed to assess fitness for purpose and alignment to the BAF. The revised Quality Assurance Framework will include the operational structures and processes.	31/10/2022	31/07/2023	Not Yet Due		**June 23**: Due to be presented to Executive Committee and PQSOC in July 2023	
External	2021.06	Quality Governance Review	Not Rated	Director of Nursing	N/A	R8	R8 The General Surgery directorate has recently established its own patient safety and quality group. However, the group does not have a terms of reference, standardised agenda, or report templates and minutes of meetings are not taken. Whilst quality and safety did feature in bi-annual reviews with the Executive Team and monthly assurance meetings with the Director of Operations. We note the monthly assurance meetings stopped in March 2021. We found limited focus on quality and safety at Scheduled Care Divisional Management Team meetings. The Health Board should:•review the operational patientsafety and quality groups toensure they are effectivelysupporting the Health Boardsquality governancearrangements.•ensure that other operationalmeetings / forums providesufficient focus on quality andsafety alongside finance,performance, and operationalmatters.	The patient, quality and safety structures for each Division will be reviewed and outlined in the revised Quality Assurance Framework (see R6).Divisions will be reminded to ensure a robust focus on patient quality and Safety through Divisional and Directorate meetings.	31/10/2022	31/07/2023	Not Yet Due		**June 23:** Quality Assurance Framework due to be presented to Executive Committee and PQSOC in July 2023	
Internal	2022.05	Digital Benefits Realisation	Reasonable	Director of Digital	Low	R2	R2 The Health Board should continue with an annual reporting cycle that summarises the benefits position for the Audit, Risk and Assurance Committee. Work on the benefits dashboard should be completed and incorporated into future reporting.	Benefits updates are provided at monthly programme boards and quarterly to Programme Delivery Board (PDB). Work is ongoing with the PMO using the informatics portfolio register to develop oversight of portfolio level benefits. A local dashboard is under development for summary reporting to DDOB on a six monthly basis. This dashboard can be updated to provide an annual update to the Audit, Risk and Assurance Committee.	01/09/2023		Not yet due			

Internal	2022.06	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	N/A	R1	Appropriate strategies should be developed to ensure that recruitment and retention issues experienced to date do not impact significantly on the achievement of the DAPs.	Agree. We shall continue to review the roles required to implement the DAP objectives and ensure effective succession planning is in place.Directly relating to Initiative 9 – Facilities Division has recently appointed a dedicated Building Management System (BMS) Officer (due in post Jan23).Through an Academy Wales graduate developmentprogramme we shall be utilising a student placement to assist with decarbonisation metrics, reporting and engagement starting in 23/24.	01/11/2023		Not yet due			
Internal	2022.06	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	N/A	R3	DAPs should be supported by funding strategies e.g. differentiating between local/ national funding, revenue or capital funding etc	Agree. Projects developed through the DAP shall be funded appropriately – ReFit, HSC, EFAB, revenue, discretionary capital.	01/11/2023		Not yet due			
Internal	2022.06	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	N/A	R5	As a major contributor to the achievement of the targeted reductions appropriate engagement will be established with NWSSP Procurement Services (and formalised as appropriate).	Agree. The DPB have requested suitable NWSSP Proc Serv. Representation at meetings to update and provide guidance and feedback on progress.Within the programme governance arrangements we have identified fourtask and finish working groups who will link with our local procurement team. In addition we also have a financial representative leading group 4 who directly links in with health board Director of NWSSP National initiatives which are reported at the Bimonthly board meetings within the health board.	01/11/2023		Not yet due			
Internal	2022.06	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	N/A	R7	Where decarbonisation falls within the existing environmental remit of committees/ meetings, it is important that an appropriate profile is set. Terms of Reference and agendas should be reviewed to ensure that sufficient focus is provided	Agree. The Decarbonisation Programme Board (DPB) within its structure has 4 subgroups each with national initiatives delegated to them. The DPB and subgroups each have ToR's and scheduled meeting frequencies.	01/11/2023		Not yet due			
Internal	2022.06	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	N/A	R10	Given the scarcity of funding, it is important that bids for funding are appropriately considered prior to submission	Agree. Funding submissions are suitably scrutinised by appropriate forums e.g. Pre-Investment Panel (PIP), Capital Programme Board or DPB.	01/11/2023		Not yet due			
Internal	2022.06	Decarbonisation - Advisory	Not Rated	Director of Finance and Procurement	N/A	R11	The same rigour and monitoring should be applied to internally commissioned/ funded initiatives to ensure the outcomes are adequately recorded/reported.	Agree. Projects shall be reported to the DPB with adequate metrics developed to measure carbon reduction potential. Such projects will also be reported to WG through the bi-annual qualitative reporting requirements	01/11/2023		Not yet due			
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Low	R2	R2 The Health Board should not embed documents / files / forms etc. within a policy document hosted on the intranet. If a form is applicable, it should form part of the appendices or be referenced separately	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), the Quality Assurance process will be strengthened and implemented.	30/09/2023		Not yet due			
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Low	R3	R3 The Health Board should consider the relevant Health and Care Standards when reviewing / updating a policy or other relevant documentation. An acknowledgement of this process should be included, together with the titles of the relevant Standards included.	The introduction of the Duty of Quality, under the Health and Social Care (Quality and Engagement) (Wales) Act 2020, will see the Health and Care Standards (April 2015) removed and replaced with Quality Standards 2023. As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), the introduction of the Quality Standards 2023 will be considered, and policy templates updated as they are reviewed/developed.	30/09/2023		Not yet due			
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Medium	R4	R4 The Health Board, alongside recommendation 3.1 should consider automating the submission of a policy from the responsible owner, to ensure that a consistent submission format is adhered to	An integrated electronic policy management system will be explored, learning from other health bodies, with an implementation plan developed to support the most appropriate system.	30/09/2023		Not yet due			

Internal	2022.11	Policies	Limited	Director of Corporate Governance	High	R5	R5 The Health Board should consider fully automating the reminder / management process of all relevant policies / documentation hosted on the intranet. This could be achieved through the use of Power Automate, Lists and other apps within Office 365. An automated work flow would undertake a periodic (e.g. weekly) check of all policies listed on the central spreadsheet that are overdue for review and issue automatic 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.	30/09/2023		Not yet due			
Internal	2022.11	Policies	Limited	Director of Corporate Governance	High	R6	R6 Once the Health Board has completed a review of all existing policy documentation, document reviews should be undertaken prior to the dates stated for review. Where exceptions remain, there should be an escalation process introduced to include the responsible Executive Director and potentially the Chief Executive Officer / Audit, Risk and Assurance Committee.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), the review and escalation process will be strengthened and implemented.	30/09/2023		Not yet due			
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Medium	R7	R7 The Health Board should complete a data accuracy review exercise of the policies and documents, alongside recommendation 2.1. Where data discrepancies exist these should be updated immediately to the correct value.	A review of the central base (881 documents) is underway, working with divisions, to review the status of each document and respective owners.	30/09/2023		Not yet due			
Internal	2022.12	Records Managment	Limited	Director of Digital	Medium	R4	R4 The management of ward clerks should be centralised, and consideration should be given to manage shortages through “bank arrangements”.	a.) Local ward clerk shortages will be escalated to the Assistant Directors of Nursingand subsequently escalated to the Executive Director of Nursing. Action plan will be agreed how to solve them. b.) The clerical bank is undertaking a rolling programme of recruitment which will benefit the short notice requirements for ward clerks and this information will be disseminated by the nursing hierarchy to the ward staff.	31/07/2023		Not Yet Due			
Internal	2022.12	Records Managment	Limited	Director of Digital	Medium	R5	R5 The need for records management storage places should be regularly reviewed to ensure that sufficient spaces are available for record keeping purposes.	This issue is to be raised with the All Wales Medical Directors Forum as Caldicott Guardians. The Data Protection Officer will raise this at quarterly meetings with the Medical Director and agree an action plan.	31/12/2023		Not yet due			
Internal	2022.12	Records Managment	Limited	Director of Digital	Medium	R13	R13 All records should be formally tracked to ensure that they are retrievable when they are needed.	a.) The Business case for DHR phase 3 is in development, this will include the scanning of paper records to be available to view in CWS/cCube Portal negating the need for tracking. b.) Future phases for community, District Nursing, children’s services and therapies are being planned and expedited and tracking will be implemented.	31/12/2023		Not yet due			
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	Low	R5	The skills development work should be formalised into a skills development plan	Agreed. The skills development plan is under development and apprenticeships are actively being explored with the support of Organisational Development colleagues. Informatics are now engaging with other Health Boards who report having commenced apprenticeship schemes	01/12/2023		Not yet due			

Internal	2022.15	IT Strategy	Reasonable	Director of Digital	Medium	R6	The Health Board should seek to align plans with other sources of digital projects.	Joint planning sessions with DHCW are now taking place and will be (following revised terms of reference and membership being agreed) considered by DDOB. DDOB will also receive escalations on funding/governance or priority issues whether local regional or national. The Programme Office will provide reporting	01/09/2023		Not yet due			
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	High	R1	The Discharge Policy is updated, approved and reissued, to be compliant with the All Wales policy, when issued.	The All Wales Discharge Policy is expected to be released imminently and will be intrinsic to the development of the new Health Board policy. We acknowledge that since the policy was published current practice has moved on so that the policy does not describe the working arrangements. A Task & Finish group will be established with cross divisional representation to redraft the policy and ensure the content reflects current and emerging practice once the new All Wales Policy has been made available. This work will be completed within three months of the introduction of the All-Wales Policy. In the meantime, and as noted above we will review the current Policy. We will report any ongoing risk and position to the QPSOG. The Health Board will ensure a process is in place for regular update and review of the new policy when reissued, reporting to the Clinical Standards Board.			Not yet due			
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Medium	R2	We recommend that Health Board management ensure that formal discharge planning training is provided to both clinical and administrative staff engaged in the pathway, including updates if the process is amended.	Within the Health Board, training for discharge planning is delivered across existing induction and education programmes: Newly qualified and overseas nurses have an introduction to discharge planning through the Journey of excellence programme. The Health Boards practice educators provide ongoing education & training on discharge planning for nursing staff. The Head of Discharge has been working with the Universities to introduce a discharge planning session into student nurse training, ensuring awareness of the fundamentals before starting in their first post. Training for medical staff is currently ward based. The Assistant Medical Director for Planning will be working with a task and finish group to standardise training. Therapy staff receive discharge training throughout their undergraduate training. Much of their work is dedicated to preparing patients for discharge to their home environment or through referral to the provisions of rehabilitation or other support. Local discharge planning arrangements are disseminated through the site and ward teams.	01/10/2023		Not yet due			

Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Medium	R2	We recommend that Health Board management ensure that formal discharge planning training is provided to both clinical and administrative staff engaged in the pathway, including updates if the process is amended.	The Health Board has a work programme for discharge to be overseen by the newly created Discharge Improvement Board, chaired by the Executive Director of Nursing. This will strategically co-ordinate the current workstreams and include oversight of the roll out of the 'optimising discharge framework' issued by the NHS delivery unit. All workstreams currently form part of the goals 5 & 6 for improving urgent care and this will now form part of the overarching discharge programme. Embedding the optimising discharge framework will be a key priority of the Discharge Improvement Board, with a launch event hosted by a number of Health Board Executives held in January 2023. Local training has already commenced with sessions delivered across the acute sites and with plans for roll out to the other hospital sites within the next 6 months. This will be supported by the national training programme to be delivered by the NHS delivery unit. The lack of procedural documentation will be addressed through the new discharge policy formation.	01/04/2024		Not yet due			
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	High	R3	All patient discharges from the care of the Health Board are effectively controlled and evidenced by issuing a timely, completed discharge notification.	The Medical Director is aware that the timeliness of some discharge notifications needs to be improved. A letter was sent to all medical staff outlining their responsibilities in respect of timely discharge notifications in 2021. This is now being followed up by the Assistant Medical Director for Planning who will be leading a task & finish group to develop standardisation of approach. This work will aim to ensure that patients are able to leave hospital with their discharge summary / notification and ensure it will be sent electronically to the GP on the same day	01/04/2024		Not yet due			
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	High	R3	Where an expected, standard processes is assessed as not required, for example discharge meetings held to discuss needs and establishment of care packages, that the assessment and conclusion be evidenced.	The Health Board acknowledges that there is inconsistency in the documentation of MDT meetings. The introduction of the Welsh Nursing Care Record (WNCR) may provide an opportunity to capture the content of discharge meetings as a digital record which clinical and admin staff can access and will formally record the actions agreed. The Health Board's Chief Nurse for Information has been engaged in this process. In the interim, the Head of Discharge will work with ward staff to introduce a consistent approach to documentation and evidence in the notes. It should be acknowledged that discharge arrangements will vary considerably depending on the assessed requirements of the individual.	01/04/2024		Not yet due			

Internal	2022.19	Discharge Planning	Limited	Director of Nursing	High	R3	A consistent discharge approach is adopted for all day care appointments and for inpatient transfers between Health Board sites	In respect of day care episodes of care, there are many diagnostic / treatment areas and specialities who have different methods of notifying both the GP and patient of the care episode. We acknowledge that this is not a standard approach with some departments combining the clinical details as the discharge summary. As part of the Task and Finish group, the Assistant Medical Director for planning will ensure that discharge notifications form part of the standardised approach. For inter-site transfers an SBAR is completed for every patient that outlines the patient's condition, diagnosis and any actions needed to be taken by the receiving	01/04/2024		Not yet due			
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Medium	R4	We recommend that the Health Board ensure all patients admitted and recorded on CWS should have either 'simple' or 'complex' discharge status noted.	The complex list is an operational tracking tool to ensure that patients who may require support on discharge are captured and all appropriate assessments completed as required. All potential complex patients are added to the complex list, so that by default the remaining patients are simple discharges. Status can change during admission as patients may deteriorate or circumstances change so that patients are added to the complex list during their admission. The allocation of a 'simple' or 'complex' label may be difficult to assess on admission and would be of little benefit operationally. In December the Health Board recommenced shadow reporting to Welsh Government for Pathways of Care Delays (replaced DTOC reporting) and provides an audit / monitoring process for all patients with a delayed discharge status. This process also includes an action plan overseen by the Discharge Improvement Board, supported by improved operational information in the discharge dashboard.	01/04/2024		Not yet due			
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Medium	R4	A method for identifying delays during the discharges of 'simple' cases should be introduced, monitored and reported	Discharge delays can affect both simple and complex discharges and therefore emphasis should be improving the process for all patients. Length of stay data is available to explore the feasibility and the benefits of such an approach. The Health Board continually seeks to identify the factors that delayed discharge and this work forms part of the workstream for goal 5 of the Welsh Government '6 Goals for Urgent and Emergency Care' programme. As part of this programme, the Delivery Unit has recently released the 'optimal patient flow framework', and the Health Board will be embedding these principles as 'business as usual'. The framework will also feature in the new All Wales Discharge Policy, to include the introduction of the SAFER principles, D2RA and 'red & green days'. These concepts have the potential to reduce LOS and improve discharge planning, so will be embedded within our policy.	01/04/2024		Not yet due			

Internal	2022.19	Discharge Planning	Limited	Director of Nursing	High	R4	The recording of transfers between sites as discharges in CWS should be investigated to determine that it is not adversely impacting the Complex List by removing patients in error when in fact they remain under the care of the Health Board	There are acknowledged limitations within the Health Boards CWS system, whereby patients need to be discharged from one hospital to be admitted to another hospital on transfer. This has been the case since the inception of CWS, and forms part of the training provided to staff on induction. Mitigation of this risk is provided as all hospital staff are aware of the need to readmit to the receiving hospital on arrival. All acute and community wards have an allocated Hospital Discharge Assistant who ensures that transferred patients who may require support on discharge are captured on the complex list. For community hospitals transfers, patients are always added to the complex list by default as they are by nature complex cases. The mitigation described ensures that patients are not lost to the complex list, and we have evidence to support this. The new discharge dashboard demonstrates that the majority of our patients are included as part of the complex list either pending assessment or provision of discharge arrangements	01/04/2024		Not yet due			
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Medium	R5	Determining whether to make the use of the discharge checklist mandatory (including which aspects to include) or not and if so, the document should be consistently completed. Performance should be monitored until fully embedded.	Discharge checklists are used by most wards; however, we acknowledge there is an inconsistent approach in their use. The Welsh Nursing Care Record is currently being rolled out across the Health Board and may provide the opportunity to make the checklist part of the digital record as part of a standardised approach. In the interim, the use of checklists will be reviewed as part of the Discharge Improvement Board workstreams. The use of checklists will be further defined in the new discharge policy.	01/04/2024		Not yet due			
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	High	R6	We recommend that the Health Board ensure that the monitoring programme is reinstated and lessons learnt from reviewing each service areas are shared throughout	The Health Board acknowledges that the monitoring as set out in the policy has not taken place. When drafting the new discharge policy we will consider the most appropriate audit mechanism to ensure that compliance is monitored and reported. The lessons learnt will be reported through the new Discharge Improvement Board and through to the 6 Six Goals Programme Board. Reporting will also be provided to the Executive Committee and PQSOC			Not yet due			

Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Medium	R7	We recommend that the Health Board continue to analyse the reasons behind re-admissions within a suitable period of time. Where themes and trends are identified that these are investigated further	The analysis of readmission rates is acknowledged as being problematic, as without clinical input at the time of readmission, our current systems are unable to differentiate between a readmission for a reason connected to a prior episode of care, or one that relates to a completely different clinical scenario. CHKS, which is the national benchmarking solution choice for Wales looks at the number of patients who have been readmitted regardless of specialty, consultant, diagnosis etc. This makes any analysis difficult to interpret or perhaps meaningless. The planning department is currently working with clinical teams to develop a number of meaningful measures to determine and understand readmission trends, and to identify where improvement is required. A number of data viewers have been developed and can provide 'bespoke' data by request. Moving forward, these measures will be included within the outcome measures and QPS insights. The Health Board has dedicated services to address frequent or 'high impact' service users that are working across Divisional Boundaries to provide alternative pathways. There is also a workstream focusing on patients at high risk of	01/10/2023		Not yet due			
Internal	2022.21	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R5	All contracts over £100k in value should be signed by both the Chief Executive & Chair in accordance with the UHB's Standing Orders (Scheme of Delegation)	Agreed - Future Projects Contract Values exceeding £100k will be signed by the Chief Executive & Chair in accordance with UHB Standing Orders.	01/03/2024		Not yet due			
Internal	2022.22	RGH Redevelopment & Expansion of Endoscopy Services	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R5	The UHB should ensure that a Project Bank Account is established and operating in line with Welsh Government policy; or an application for this project to be exempt is confirmed.	It is now too late to implement a PBA at this project. WG were made aware of the absence of a PBA at the informal CRM meetings whilst a formal application for an exemption at this project was not submitted, we will ensure due process is applied at future developments.	01/12/2023		Not yet due		Action complete - PPR templates included in the papers for Project Team & Programme Board.	
Internal	2022.22	RGH Redevelopment & Expansion of Endoscopy Services	Reasonable	Director of Strategy, Planning & Partnerships	Low	R7	There should be consistency between the capital procedures and the SFIs in terms of minimum competition levels	It is understood that Capital Procedures and SFIs are both currently being reviewed and updated. The need for consistency between the two has been highlighted.	01/09/2023		Not yet due			
Internal	2022.22	RGH Redevelopment & Expansion of Endoscopy Services	Reasonable	Director of Strategy, Planning & Partnerships	Medium	R7	An evaluation should be undertaken to determine that value for money was achieved, and why there was little interest from the market; this should inform future tendering exercises.	The tender evaluation report does explain the process that resulted in there being only 2 returned tenders. The reasons for companies not wishing to tender are also stated. The pre-tender estimate was shared with Shared Services and the returned tender scrutinised by all parties. Whilst no concerns were raised at this project, we will ensure at future projects, tenders are fully evaluated against the PTE and any significant variations and reasons for the same are highlighted at the tender report.	01/12/2023		Not yet due			

Internal	2022.25	Integrated Wellbeing Networks	Reasonable	Director of Public Health	Medium	R1	Management should formalise the approach to communicating/monitoring local IWN plans and providing cover if the Service Development Lead is absent	The strategic development plan for the IWN programme for 2023/24 has identified a need for the Distributed Leadership Group, with representation from each local authority and the Community Voluntary Councils in Gwent; it is anticipated this will enable shared ownership of the IWN programme between agencies and for the IWN's place-based agenda to become more embedded in the delivery plans of partnership agencies. Alongside this, Regional Partnership Boards have now created in Gwent 5 Integrated Partnership Service Boards (ISPBs), in each local authority area, responsible for strategic and service planning between health, local authorities and the third sector. With the IWN programme and officers now embedded in these ISPBs, the programme seeks from 2024/25 onwards for local IWN wellbeing plans to be approved by ISPBs to ensure robust governance and approval. The development of place-based wellbeing plans in each of the collaborative areas, in which the IWN programme works, has to date been led by our Service Development Leads (SDLs), in partnership with the place-based collaborative members. Plans are developed locally based on feedback and direction from community and	01/04/2024		Not yet due			
Internal	2022.25	Integrated Wellbeing Networks	Reasonable	Director of Public Health	Medium	R1	Management should formalise the approach to communicating/monitoring local IWN plans and providing cover if the Service Development Lead is absent	Community Involvement Officer colleagues are often able to deputise in the absence of the SDL. The programme will explore sharing meeting facilitation with community partners and with the appointment of an 8b Programme Manager (currently out to advert) how the programme can support local meeting facilitation and programme delivery where SDL colleagues are absent for prolonged periods	01/08/2023		Not yet due			
Internal	2022.25	Integrated Wellbeing Networks	Reasonable	Director of Public Health	Medium	R2	Management should clearly identify what a successful IWN project is, and future projects undertaken by the local IWN communities (e.g. projects identified within the IWN annual plans) should state SMART goals whereby the success of the project can clearly be defined. Management should also identify what success of the IWN programme in each community looks like and once that target is achieved be able to move to other areas of need and implement the programme within those locations	An independent advisory group of academics has been created due to meet in July 2023 to advise on (a) measures of evaluating progress towards the strategic objectives of the IWN programme in each place-based area of operation and (b) longitudinal methods for measuring community wellbeing in an evidence-based manner to understand how and whether the IWN programme is impacting on population wellbeing in its place-based areas. It is anticipated by September 2023 that a new evaluation framework will be proposed by this advisory group, with funding now apportioned for the appointment of a commissioned researcher to undertake an evaluation and embed this framework in programme monitoring for IWN into the longer-term. This will set the direction of success for local IWN projects, allow SMART goal planning and measure the success of the programme to enable exploration of working in other geographic areas in future. The evaluation work will be complete by 31st October 2023. The programme is planning to apply the King's Fund model for community-orientated needs assessment in defining success in each of the IWN areas to set goals for local areas and establish measures of success	01/10/2023		Not yet due			

Internal	2022.26	Contract Mangement	Reasonable	Chief Operating Officer	High	R1	We recommend that Health Board management ensure that a contract management policy and guidance is developed, approved, issued and communicated to all relevant staff. It should incorporate the following: 1. guidance over the operational management responsibilities associated with contracts, including the management / identification of contract risks, performance monitoring, escalation of matters arising etc.; 2. template documents to record details of how individual contracts are to be managed e.g. responsibility for oversight and delivery. This is particularly important where the responsibility lies across different functions within the Health Board; 3. the All Wales Procure to Pay e-Manual, issued by NWSSP Procurement includes a section on implementation and contract management processes and provides information that should be aligned to any position developed by the Health Board; and 4. the Procurement Policy and Financial Control Procedure is updated to incorporate any relevant references as a result of the above changes.	A contract Management Policy is in the process of being developed and due to be drafted by the end of July 2023 for consideration and approval by end August 2023. The policy will make reference to standard documentation in order to standardise the approach to contract management across the Health Board, and form a FCP	01/08/2023		Not yet due			
Internal	2022.26	Contract Mangement	Reasonable	Chief Operating Officer	Medium	R1	The introduction of contract management guidance and policy should be supported by the roll out of an appropriate training programme to all relevant staff, to assist with the embedding of the agreed approach.	Once the Policy is finalised a training programme will commence for all contract managers delivered by the Head of Procurement and Assistant Head of Procurement, supported by the Divisional Finance Business Partners.	01/12/2023		Not yet due			
Internal	2022.26	Contract Mangement	Reasonable	Chief Operating Officer	Medium	R2	We recommend that Health Board management ensure that: a. A repository of all signed contractual documentation is established to include: all contract schedules, framework agreements, service level agreements, call off orders etc. b. The repository is placed on a shared platform such that it is accessible to all relevant staff / stakeholders.	This is difficult as Procurement services who maintain the bulk of any contract documentation sits under NWSSP who have their own architecture within SharePoint which is not readily accessible to Health Board staff. It is proposed in the contract management policy that a contract management plan will be drafted between procurement and the responsible division/contract manager with information to be issued back to procurement at regular intervals. This will ensure that all contract documentation is kept in one place and is accessible by contacting the procurement team.	01/12/2023		Not yet due			

Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Medium	R1	Formal deadlines should be set by the Health Board to ensure the timely delivery of actions to maintain compliance with the Standards. Performance against these deadlines should be monitored and reported on.	The Standards have been developed and published by Improvement Cymru. There are no National Deadlines set for the Standards. This is continuously evolving and will help all Health Boards/regions to influence, shape and improve dementia care over coming years. These are the first 20 Standards and we anticipate that new standards will be introduced by Improvement Cymru over the coming years. We have updated the Board and Quality Patient Safety and Outcomes Committee of work undertaken during the readiness year. The Regional Dementia Board consider all the standards which are part of the dementia action plan, and this is also fed back to the Regional Partnership Board. The newly appointed Dementia Programme Manager will oversee all workstreams and, alongside reporting progress, we will report by exception any issues relating to implementing the Standards. Should Improvement Cymru produce deadlines, we shall revisit this recommendation. Additionally, once KPIs have been developed over the next 12 months, we will consider how we can best set formal deadlines for reporting. Auditors' comment on management response We agree with the current	01/07/2024		Not yet due			
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Medium	R2	Spot checks / audits should be regularly carried out to review compliance with the Enhanced Observation Framework.	The Enhanced Care Framework, although not specific to Dementia aims to guide staff through what to consider prior to securing additional support. The enhanced observation policies are different on all Mental Health and Learning Disabilities Units. We shall use this recommendation to review the enhanced care framework and associated policies. Workstream 4 leads will be asked to review the Enhanced Care Policy and determine how this can better align to VIPS monitoring for people with dementia.	01/10/2023		Not yet due			
Internal	2022.24	Infection Prevention & Control (OPC)	Reasonable	Director of Nursing	Medium	R1	Management should undertake a walk around / review of wards covered in this audit to ensure areas of noncompliance have been addressed. Any lessons to be learnt should be shared with the remaining wards to ensure compliance throughout the Health Board.	Email circulated to Divisional Nurses on the 30.05.23 asking for the above recommendation to be implemented and update via local quality and patient safety forums and the Reducing Nosocomial Transmission Group. Dashboard audits are available on the AMaT platform	01/07/2023		Not Yet Due			
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Medium	R3	It should be clearly defined and communicated in what circumstance alerts should be used. In addition, staff should be trained on how to add alerts to the system	We will review the training and electronic filing requirements for 'alerts' and ensure that clear messages are communicated to the relevant staff	01/07/2023		Not Yet Due			
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Low	R3	Training should be provided to ensure a consistent approach for the electronic and paper records completion	We will review the training components and update where required, to ensure a consistent approach is adopted	01/07/2023		Not Yet Due			
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Low	R4	Consideration should be given to formally monitor (e.g. set KPIs) and report on • patients hospitalised outside of their catchment areas; and • moved from one hospital site to another one over their treatment time	Workstream 5b (measurement) will consider appropriate KPI's and will extend an invitation to the Patient Flow Team to be members of the workstream	01/08/2023		Not yet due			
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Low	R4	Where operationally and clinically possible, a patient's locality should be considered as part of the admission / transfer process	Patient Flow Team to consider this specific aspect, linked to the developed KPI's above	01/09/2023		Not yet due			

Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Low	R4	There should be easily available information / training for staff to ensure patients can communicate with Welsh speaking staff.	The Workstream 4 (Hospital Charter) to link with the Welsh Language Lead and Workforce and Organisational Development leads to identify the number of Welsh Speaking Staff, identify how we can better identify Welsh Speakers and ensure access to Welsh Speakers as part of our Person Centred Care Dementia Care work programme.	01/09/2023		Not yet due			
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Low	R5	Local initiatives with success stories should be channelled and discussed at existing forums.	Patient Stories are used at MDT learning events, at Board, through the Quality and Patient Safety Operational Group (QPSOG) and Board. Discussions have taken place within the Person-Centred Care Team to develop a digital portal for all patient stories. Listening and Learning is reported at QPSOG. There are also early discussions around establishing a Community of Practice for patient experience to share learning and celebrate success/best practice (September 2023). The Dementia Specialist Practitioner through the VIPS work will be key to sharing best practice/success stories across all hospital wards.	01/09/2023		Not yet due			
Internal	2022.28	Mental Health Transformation	Reasonable	Chief Operating Officer	Medium	R1	The control and oversight of each individual mental health transformation project is formally allocated, documented and communicated to all interested parties to the project. This should include any third-party bodies engaged and ensure that any duplication or omission of effort is identified and addressed. There is a need to ensure that assurance mechanisms, including those provided by third-parties can be relied upon. b. Any such document should ensure that key aspects of a project's development and implementation are considered including time, cost, benefits, linkage of projects to strategic objectives, management of risk and ongoing monitoring of targets etc.	A review of the control and oversight of each of the individual mental health transformation projects will be undertaken to ensure it is appropriately allocated, documented and communicated to relevant stakeholders. The document will cover the areas outlined in recommendation 1.1b	01/10/2023		Not yet due			
Internal	2022.28	Mental Health Transformation	Reasonable	Chief Operating Officer	Medium	R1	The Whole Person Whole System Crisis Support Programme Board and the Mental Health Transformation Board established to provide oversight have Chairs appointed who are independent of divisional management to demonstrate and deliver the independence required of	A review will be undertaken regarding the Chairs of both the WPWS Crisis Support Programme Board and Mental Health and Learning Disability Transformation Board.	01/09/2023		Not yet due			
Internal	2022.28	Mental Health Transformation	Reasonable	Chief Operating Officer	Medium	R1	The Project Flash Report format should be amended to include a section on matters for escalation. Any such matters should be reported as part of a standing item within the appropriate board setting (i.e. Whole Person Whole System Crisis Support Programme Board or the Mental Health Transformation Board). The minutes should reflect the matters to be escalated or state no matters for escalation. This is also applicable of matters for escalation from the Mental Health Transformation Board.	The Project Flash Report format will be amended to include a section on matters for escalation. Any such matters for escalation have previously been verbally reported and will be reported more clearly as a stand alone agenda item within the appropriate board. For clarity, going forward the minutes will also reflect the matters to be escalated or state no matters for escalation.	01/08/2023		Not yet due			
Internal	2022.28	Mental Health Transformation	Reasonable	Chief Operating Officer	Medium	R1	The Whole Person Whole System Crisis Support Programme Board performs deep dives into projects to further scrutinise the information received in the Project Flash Reports.	Within the current structure of the Whole Person Whole System Crisis Support Programme Board there is currently the ability to focus on details regarding specific projects. However, a more formal approach to "deep dives" for individual projects will be introduced (12 monthly minimum) that will include comprehensive performance and benefits reporting.	01/09/2023		Not yet due			

Internal	2022.28	Mental Health Transformation	Reasonable	Chief Operating Officer	Medium	R1	Consideration be given to the Whole Person Whole System Crisis Support Programme Board only receiving the Project Flash Reports and for this Board to then report by exception to the Mental Health Transformation Board on matters detailed in the reports	The Mental Health and Learning Disability Transformation Programmes (Whole Person Whole System Crisis Support Programme and Complex Needs Programme) will receive the Project Flash reports for all workstreams and those Boards will then report by exception to the Mental Health and Learning Disabilities Transformation Board.	01/09/2023		Not yet due			
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Low	R3	Consideration should be given to revisit the appropriateness of the paper folder file style for the MHUs, to improve efficiency of access to patient files	The OAMH Directorate will review the paper folder files and implement any improvements required.	01/07/2023		Not Yet Due			
External	2023.02	Structured Assessment 2022	Not Rated	Director of Corporate Governance	N/A	R1	R1 Board and Committee agendas cause some meetings to overrun. The Health Board, therefore, should review Board and committee agendas to ensure meeting business can be covered in the time available whilst also allowing for sufficient scrutiny and discussion.	Ongoing development of the Board's Assurance Framework and Risk Management Framework will enable the Board and Committees to ensure focus on priority, risk-based, areas by exception, supported by risk-based workplans. The development of Board and Committee Etiquette and Conduct of Business will also support greater effectiveness of meetings.	01/09/2023		Not Yet Due			
External	2023.02	Structured Assessment 2022	Not Rated	Director of Corporate Governance	N/A	R7	R7 The Health Board's deteriorating financial position and deterioration in savings deliver indicates that stronger accountability for financial performance and delivery is required. The Health Board, therefore, should review its Scheme of Delegation to ensure it more strongly outlines delegated accountability for the budgetary position and achievement of financial efficiencies at and below executive levels.	The Health Board's existing accountability arrangements have been endorsed by the Audit, Risk & Assurance Committee and is aligned to Standing Orders and Standing Financial Instructions. The Executive Team has commenced work with the organisation's senior leadership team to further embed a culture of empowerment, autonomy, authority and accountability, building on existing arrangements in place. This Framework will cover all aspects of the organisation's business (not just a focus on finance) and will be presented to the Board for consideration in March 2023. Upon approval, further work will be required to support the embedding of the framework in practice.	30/09/2023		Not Yet Due		Approval of Framework 30 April 2023 Embedding of the Framework will be ongoing	

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	12 September 2023
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Risk Management Update
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

This report seeks to provide the Committee with an update on the refresh of the Board's Strategic Risk and Assurance reporting arrangements, aligned to the Risk Management Strategy.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Since the Board meeting in July 2023, when the Health Board's strategic risks and refreshed approach to risk and assurance reporting arrangements were agreed upon, work on the structure for risk management reporting, the revised 'Risk to a Page' template, which will inform the development of the Strategic Risk and Assurance Report have progressed.

An initial assessment of the current Risk Management Strategy has been completed, and preliminary work on establishing a baseline for the revised strategy has started; benchmarking against Health Boards in Wales and England has provided insight into the gaps in our current strategy and areas for improvement.

NB: It should be noted that the Health Board's current strategy, version 9, remains the extant strategy until an updated version is approved by the Board.

Cefndir / Background

The Health Board's risk management approach outlined within the current risk management strategy allows for risks to be escalated through the system, as well

as strategic risks to be identified by the Executive Team and the Board, however, it is recognised that the strategy needs to be matured and strengthened to provide absolute clarity on reporting hierarchies, triggers, and thresholds.

The Board has recently held facilitated development sessions on risk appetite and tolerance. The results of which will be a fundamental component of the updated Risk Management Strategy.

At its meeting in July 2022, the Committee approved the Risk Management Benefits Realisation Plan (Appendix 1), which will aid in the development of the refreshed Risk Management Strategy. Furthermore, the plan will be updated in accordance with the work being undertaken to identify any gaps in the strategy to ensure that the Board is informed, engaged, and confident in the approach that the Health Board takes to identify and manage perceived risks.

Asesiad / Assessment

Risk Management Approach, Methodology and Strategy Update

Since the Board meeting in July, work on revising the Risk Management Strategy has begun to clearly articulate the Health Board's risk escalation process and assurance systems.

A clear escalation structure with agreed-upon escalation thresholds at each level will be included in the revised Risk Management Strategy. To bridge the gap and manage any divisional risks that require executive intervention and monitoring, an Executive Risk Register (ERR) is being established. Operational risks being escalated to the Strategic Risk Register (SRR) will therefore be avoided by adding an additional layer of control, as will inconsistency in reporting and risk scoring.

The escalation process is shown below in Figure 1.

Figure 1

In addition, the proposed draft risk appetite that has been developed with the support of NHS Providers will form part of the revised Risk Management Strategy

and will help to strengthen the escalation framework and promote consistency of risk scoring, based on risk appetite levels. This will enable the Board and its Committees to take assurance that risks are being managed effectively at the most appropriate level.

As part of the refreshed approach, the 'Risk to a Page' template used to support reporting of the Strategic Risk Register has been simplified, attached to this report as Appendix 2. Given where the Health Board is in its Risk Management journey the previous template was deemed too complex and required simplification. As the Health Board's risk management system matures so will reporting.

There are **8** high-level strategic risks identified, with **18** sub-sets in total. A 'risk to a page' template for each of the 18 sub-risks has been created and shared with Executive Directors; these are currently being completed in preparation for the Strategic Risk Report to the Board in September.

The Head of Corporate Risk and Assurance has met with the Head of Health and Safety to discuss creating bespoke risk registers within the Datix legacy system in order to deliver parts of the Risk Management Benefits Realisation Plan. This will increase risk transparency and provide greater intelligence of the risks held at the divisional, executive, and Board levels. This will also strengthen the reporting and escalation arrangements.

Initial discussions with those responsible for risk management revealed that Datix is not widely used for risk management across the organisation. The already established Risk Management Community of Practice, which will be renamed the Risk Compliance and Awareness Group, will serve as a mechanism for reporting risks to the responsible Executive Director and, if necessary, the Executive Risk Register. The Group will also assist Risk Leads in transitioning from Excel to the live risk management reporting system, as well as provide the tools and support needed to effectively manage issues/risks and potential risks in their respective areas.

To ensure the effectiveness of the group a review of the membership is being undertaken to ensure there are representatives from all areas at an operational and corporate level.

Furthermore, the Head of Corporate Risk and Assurance has begun collaborating with Divisional Quality & Patient Safety (QPS) Leads to attend divisional QPS meetings in order to revitalise risk management and assist divisions in developing risk registers, which will be reported at the bi-monthly Risk Compliance and Awareness Group.

An update on the status of the anticipated Once For Wales (OFW) RLDatix Risk Module was provided at a recent meeting of the OFW Risk Management Task and Finish Group. Unfortunately, issues with the functionality continue, so Datix has agreed to keep the legacy system operational until November 2024 whilst furtherwork is progressed to deliver a fit-for-purpose system.

There is a potential risk to the Health Board if the RLDatix risk module is not nationally approved for use before November 2024 as the Health Board will not

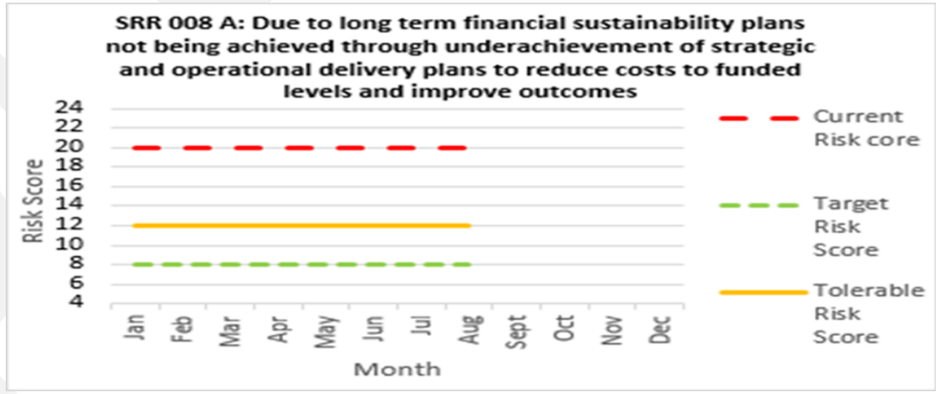
have access to a bespoke risk management system. The risk has been captured on the Corporate Governance Risk Register as a potential risk and discussions continue at the OFW Risk Management Task and Finish Group and at the local Datix Cymru Project Group on contingency plans should the risk materialise.
Argymhelliad / Recommendation The Committee is requested to: ➢ **RECEIVE** the update on the refreshed approach to Risk Management for assurance.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	The Corporate Risk Register is informed by Datix, ensuring a bottom-up approach to risk escalation.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. The Corporate Risk Register assesses risk that could impact achievement of all strategic priorities.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	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:	

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/	Choose an item. Choose an item. N/A

RISK THEME	FINANCIAL SUSTAINABILITY					
Strategic Risk (SRR 008)	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**					
Strategic Threat	Due to long-term financial sustainability plans not being achieved through underachievement of strategic and operational delivery plans to reduce costs to funded levels and improve outcomes.				**Risk Appetite Level**	**Cautious.** The preferred appetite of the Board is to be **Cautious,** however, in the current environment, the Health Board and NHS Wales are **Open** to considering all potential options to achieve its strategic objective.
					Risk Appetite Threshold	**Score 13 and below**
Impact	➢ Breach of statutory duty to breakeven over 3 years. ➢ Instigation of NHS Wales Escalation & Intervention Arrangements. ➢ Non–delivery of health board priorities, required improvements, and achieving longer-term sustainability. ➢ Prioritisation and possible disinvestment in service delivery. ➢ Reputational damage and loss of public confidence.					
Lead Director	Director of Finance and Procurement	**Risk Exposure**	**Current Level**	**Tolerable Level**	**Target / Appetite Level**	
Monitoring Committee	Finance & Performance Committee	**Likelihood**	**5** (Almost certain) x	**3** (Possible) x	**2** (Unlikely) x	
Initial Date of Assessment	01/06/2023	**Impact**	**4** (Major)	**4** (Major)	**4** (Major)	
Last Reviewed	18/08/2023	**Risk rating**	**= 20** (High)	**= 12** (Moderate)	**= 8** (Moderate)	

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)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Control** *(Specific areas/issues where further work is required to manage the risk to accepted appetite/tolerance level)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment based on the information supplied)*
	Level 1 Reassurance *(Implemented by the department that performs daily operation activities)*			**Gaps in Assurance**	Use Guidance Note for determining rating
	Implemented by the department that performs daily operation activities. *E.G. Day-to-day Management of Risk, Adherence to policy & procedures, Reporting Structures*				
	Level 2 Internal *(Executed by risk management and compliance functions)*			**Actions to Address Gaps**	
	Executed by risk management and compliance functions. *E.G., Provides Frameworks, Policies, Toolkits, Systems, Reviews, Reporting Structures*				
	Level 3 External *(Implemented by both auditors internal (NWSSP) and external (AW))*				
	Implemented by both auditors internal (NWSSP) and external (AW). *E.G., Inspections, Reviews, Audits*				

Appendix 1

Approved Risk Management Strategy Realisation Plan 2022

Strategic Objective Stated within the Risk Management Strategy (2021)	Action(s)	Responsible Officer	Deadline/Governance Oversight	What are the Benefits?	Update – September 2022	RAG Rating
❖ (1) Develop a suite of documentation including protocols and procedures to underpin and support the embedding of the strategy and associated risk management approach within the organisation.	Development of a toolkit to include agreed definitions relating to risk e.g. risk vs issues, examples of good practice. Provide organisational clarity on the risk management escalation process. Develop a quarterly newsletter on risk management to be shared will all staff including useful shared learning links.	Head of Corporate Services, Risk and Assurance	**May 2022** – Executive Team for endorsement and then wider cascade organisationally.	Provide staff with the tools to enable the strategy to be optimally realised and implemented and equip the Health Board with the appropriate infrastructure to become a risk intelligent organisation, with enhanced focus on most appropriate areas.	The toolkit remains in the development stage with a view to progressing this by end of December 2022.	
❖ (2) Understand the risk environment and adapt and remain resilient to changing circumstances or events.	This objective will be addressed via the internal training package as outlined in **objective 4**. Internal Audit will always undertake reviews in relation to risk management, the results of which would then be used to track and monitor compliance and uptake rates in relation to risk management training.	Head of Corporate Services, Risk and Assurance	Timelines for risk management training outlined within **objective 4**. **September 2022** – Board review as part of the 1-year review of the Risk Management Strategy.	By understanding the environment and context of the risk, the action plan, mitigations and monitoring of the risk becomes clearer. Only by understanding our risk environment and the potential impacts can the Health Board really determine how we manage the risk going forward. By achieving this objective, the Health Board will become more risk focussed and will further support alignment to the BAF and cultivate stronger risk management practices throughout Divisions.	Risk Management training updates are listed under objective 4. Much progress has been made however, there has been some slippage on deadlines *see below updates*	

❖ (3) Use performance data and business intelligence around risks to underpin strategy, business planning, decision making and allocation of resources and to assess whether or not objectives are being met.	At a Corporate/Strategic level, reporting on key deliverables associated with key programmes of work as outlined in the IMTP will be risk stratified and monitored at Executive Team, HSLG, Committees and the Board. Risks identified as threats to successful achievement of Health Board objectives will also be highlighted, monitored and managed via the BAF. An assessment against levels of assurance (internal and external) will also be undertaken as part of the review of the BAF 2022/23. At a Divisional/Operational level, Divisions will be encouraged and supported to consistently map their performance data to their respective risk areas to measure and demonstrate efficacy of internal controls and to use these metrics when reporting at Divisional assurance meetings for example.	Head of Corporate Services, Risk and Assurance	**May 2022** – Board, as part of the revised BAF to reflect the revised IMTP an assessment on risks to delivery, internal controls and levels of assurance will be undertaken. Committee agenda setting meetings will continue to be influenced and informed by the BAF. This means that whilst the Committee strategic risk reports will highlight the overall risk position, items on Committee and Board agendas should draw out the assurances required to demonstrate risks are being managed appropriately.	Using performance data in relation to management of risks will provide a level of assurance to the organisation and the Board and will enable clear understanding of which controls are working and importantly, which controls are not. Using data can also support risk management exit strategies and helps to predict future potential risks and promotes 'one version of the truth' reporting.	Committee agenda setting meetings are beginning to utilise the Corporate Risk Register to inform agendas and items for business. As further iterative work is developed on the Board Assurance Framework, this will then become a tool for informing business and providing Board and Committee members with the direction to review gaps in assurances and ensure risks are being managed appropriately. The Board received in July 2022 its first tranche of risks to approve that has been informed by reviewing the electronic risk management system within the Health Board. This has taken the organisation a step closer to using business intelligence to inform corporate/strategic risks and is a significant step forward in realising the benefits of the risk management approach. Audit Committee in August 2022 discussed the need for a refreshed approach to the development of the BAF and process assurance maps. Developmental work will continue through Q3/4 to enable the Board to have a refreshed assurance system for April 2023.	

❖ (4) Develop an electronic training programme incorporated into the induction of all employees, more in depth training for managers and specialised training for Board members.	Develop an internal risk management training package for staff at all levels including: • Revised template CRR with examples of good practice and notes • Clarity on what is a risk and what is an issue • Clarity on internal controls and action plans • Clarity on examples of good assurance • Ensure consistency of language when populating DATIX fields to enable consistent reporting • Exit strategies for risks • Positive/opportunity risk management	Head of Corporate Services, Risk and Assurance	**March 2022 –** identify risk champion roles within each Division and encourage their attendance at the Risk Managers Community of Practice Meetings. **May 2022 –** Basic training for all staff to be made available and will incorporate some of the suite of documentation developed as part of objective 1. **June 2022** – Management level training packages to be developed and shared through DMTs/HSLG/Divisional QPS meetings **July 2022 –** Board level risk management training to be delivered. **Board May 2022** – the Health Board will request an extension on the implementation of the revised risk management module to facilitate full engagement and allow training packages to be developed.	Relieve pressure on operational colleagues when populating and reporting Directorate and Divisional risks	Achieved/Completed Ad-hoc awareness raising and support is delivered to teams through a targeted approach utilising capacity available. Systematic training will be made available and roll out of this is being considered through the OfW implementation plan. Divisional engagement has been undertaken alongside robust reviews of Divisional risk registers. Colleagues have been requested to 'cleanse' their risk data and utilise the risk register to drive the business of the Health Board. Board level training options is being explored for external facilitation and an update will be provided at the February 2023 Committee meeting following a Board Development Session on Risk Management in January 2023. National work on the OfW RL Datix risk management system has been stalled due to factors outside of the Health Board's control.	

					An update is anticipated from the National team is expected imminently.	
❖ (5) Develop a culture where active risk management is integrated into all Health Board and Partnership business.	Ensure risk item remains on all Executive Team and Strategic Group meetings and encourage DMTs and Divisional Assurance Meetings to follow example. A monthly specific risk report to be developed for Executive Team which requests active participation from Exec Team members to be introduced and predicates discussions on risk management at Committee and Board meetings.	Head of Corporate Services, Risk and Assurance	**Executive Team/Strategic Group/DMTs/HSLG/QPS meetings/Board** – 2-3 years to fully embed. **March 2022** - Executive Team	Promote a culture whereby risk management is seen as a positive performance management tool and not a bureaucratic exercise.	Active engagement with Divisions and Executive Team to encourage risk management discussions at DMT/SMTs has taken place. The Head of Risk and Assurance has a progressive plan in place to ensure consistency of messages, approach and language is adopted and promoted with all Divisions including enabler Divisions.	
❖ (6) Clear definitions and clarity on the organisational risk appetite.	Re-set the Health Board Risk Appetite Statement (to include risk tolerance and capacity levels),definition areas and escalation routes in line with Health Board agreed Emergency Pressures and Escalation Policy (2021)	Head of Corporate Services, Risk and Assurance	**Board Development Session May 2022** – as part of development of revised BAF and following Board receipt of revised IMTP.	Provide absolute clarity and consistency on organisational risk appetite, how it links to risk treatment and if we are operating within it.	Board level training options is being explored for external facilitation and an update will be provided at the February 2023 Committee meeting following a Board Development Session on Risk Management in January 2023.	
	Communicate and embed the agreed risk appetite developed by the Health Board and informed by Nationally using agreed risk definitions from OfW	Head of Corporate Services, Risk and Assurance	Executive Team/Healthcare Systems Leadership Group/DMTs – **June/July 2022**	Promote consistency of approach across the organisation, empower staff to locally manage an down their respective risks and support in the realisation of the aspirations of the Risk Management Strategy.	A risk appetite session has taken place with the risk management community of practice however, an overarching review of the Health Board risk appetite will take place as outlined above. Locally, Divisions have been asked to consider their own risk appetites and if BCPs and triggers and escalations reflect that.	

❖ (7) Ensure appropriate structures, capabilities and capacity are in place to manage risks with clear escalation levels and processes.	Further strengthen current governance structures to ensure risk informs agendas and is allocated adequate time at Divisional and Strategic meetings. Cultivate a culture where the 'Ward to Board' approach is adopted and enacted. A clear risk escalation framework with agreed definitions and triggers to be developed (in conjunction with the Board and Senior Divisional leaders) and communicated throughout the Health Board. A clear role for the Risk Management Community of Practice in championing risk management across the organisation.	Head of Corporate Services, Risk and Assurance	**March 2022** – Ensure adequate timings for risk discussions on Committee and Board agendas. Encourage Divisional Assurance meetings to include a specific risk item to ensure respective. Executive Director led risk management to be deployed through Divisions and Directorates which is aligned to agreed escalations. Cultural change to risk management – **2- 3years** **April/May 2022 – Development and communication of risk escalation framework to dovetail with baseline risk management training.**	Clear escalation frameworks for risk empowers local staff to own their risks and provides them with assurance that mechanisms are in place to support them through an escalation process. This also provides enhanced assurance to the Board in respect of accountability at the various levels throughout the organisation. In the interests of openness and transparency, a clear governance framework for risk will ultimately enhance patient experience and public confidence.	Whilst some progress in relation to this action is underway, it is recognised that further work is required in order for the Health Board to be explicitly clear on escalation routes in relation to risk management. It is anticipated that the revised risk management module will support this approach alongside clear escalation frameworks outlined within a reviewed risk management strategy for the organisation.	
❖ (8) Create an electronic risk management system which is user friendly and allows prompt assessment, mitigation and escalation of risk.	Implement the OfW risk management module across the Health Board ***requires separate implementation plan, developed and owned by the ABUHB OFW project group* NB: BCUHB are early adopters of this module and are developing their own implementation plan which could then be used across other Health Board in Wales.***	Head of Corporate Services, Risk and Assurance	**December 2022 –** an implementation for RLDatix Risk Management Module plan to be presented to the **July 2022** Audit, Risk and Assurance Committee.	Enable consistent reporting, increase understanding of risk management at all levels and enable to Health Board to achieve its objectives.	An electronic risk management system is already in place within the Health Board however progress has been limited in relation to the revised module. An update on the National position is anticipated for September 2022 and further plans to implement the module and final date for 'go live' will be shared as the information becomes available.	
❖ (9) Ensure the risk management system is supported by robust and clear monitoring and reporting	Review current QPS and risk management arrangements and ensure that gaps are addressed for example, provide a mechanism for Divisional Directors and respective Executive Directors to discuss most significant risks.	Head of Corporate Services, Risk and Assurance	**March 2022** – Ensure adequate timings for risk discussions on Committee and Board agendas. Encourage Divisional Assurance meetings to include a specific risk item to ensure respective Executive Directors are made aware of	Clear escalation frameworks for risk empowers local staff to own their risks and provides them with assurance that mechanisms are in place to support them	Although some progress in relation to raising awareness of risk management and ensuring it has appropriate agenda timings on critical meetings, on the whole there has been limited	

processes at all levels in the organisation.	Ensure escalation routes and accountability for mitigating actions is clear for risks. Encourage consistent reporting using agreed themes and reporting trends to be used to inform strategic risk profiles and the Board Assurance Framework,		most significant Divisional risks. Cultural change to risk management – **2- 3years April/May 2022 – Development and communication of risk escalation framework to dovetail with baseline risk management training.**	through an escalation process. This also provide enhanced assurance to the Board in respect of accountability at the various levels throughout the organisation. In the interests of openness and transparency, a clear governance framework for risk will ultimately enhance patient experience and public confidence.	progress in relation to escalation frameworks. A wider piece of developmental work needs to be undertaken with colleagues to understand the emergency pressures escalation policy and how the risk management (both strategically and operationally) can be informed by that process.	

Internal Audit Progress Report

Audit, Risk and Assurance Committee

September 2023

Aneurin Bevan University Health Board

NWSSP Audit and Assurance Services

Contents

1. Introduction

The purpose of this report is to:

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

2. Remaining 2022/23 Internal Audit Reports

The following review is now finalised and reported to this Committee. There was no amendment to the draft rating.

Audit	Final Rating
Review of Bank Office and Temporary Staff	Reasonable

Further information over the assurance rating detailed above is included within Appendix B.

The following review remains in draft pending receipt of management responses and is therefore not being submitted to this Committee.

Audit	Draft Rating
Putting Things Right	Advisory review

3. Progress against the 2023/24 Internal Audit Plan

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

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

Number of audits in plan:	29
Number of audits reported as final	2
Number of audits reported as draft	0
Number of audits work in progress	8
Number of audits at planning stage	3
Number of audits not started	16

The following 2023/24 final reports have been issued since the meeting of the Audit, Risk and Assurance Committee on 18th July 2023:

AUDIT ASSIGNMENT	ASSURANCE RATING
Safeguarding	Reasonable
IMTP	Reasonable

The delivery profile of the audits is illustrated within Appendix A.

4. 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 reasonable assurance reports issued since the last meeting on 18th July 2023.

Review of Bank Office and Temporary Staff (reasonable assurance)

The audit sought to review the Bank Office and Temporary Workers process. We also undertook follow-up audit work over the process for contract and off-contract nursing agency.

Overall, we found good processes in place within the Bank Office. The controls are well defined and adhered to, but we recommended a couple of improvements, including anomalies with the electronic shift and agency timesheet approval.

We also completed follow-up work on the recommendations raised within the 2022-23 Use of Off-contract Agency audit (rated limited assurance). We found improvements had been made with the authorisation process and introduction of new controls. However, the testing completed previously over the timeliness of the notification of shifts overlapped with our audit work within the Bank Office and thus, is interlinked with audit objective three. As the recommendation from the Use of Off-contract Agency is still relevant and tracked on the Audit Recommendation Tracker, we have not raised an additional one. However, we took the updated position into account for the assurance rating.

Safeguarding (reasonable assurance)

This audit was undertaken to assess the implementation of the safeguarding controls at a corporate level within the Health Board. We found strong controls within the Safeguarding Team and Level One and Level Two training compliance close to the KPI of 85% (84% completed), across the Health Board. However, we raised a recommendation over the Level Three training requirements, most notably ensuring the training plan is prioritising the right staff.

We also tested a sample of 12 safeguarding reports (children and adult). We found that two forms had not been submitted within 24 hours, as required. We investigated this further and found additional controls that identified these reports. Upon completing this review, we assessed additional evidence and were satisfied that there was no material risk. However, we have raised a recommendation relating to this exception.

IMTP (reasonable assurance)

The audit assessed the Health Board's processes for monitoring the delivery of IMTP objectives and thus, strategic objectives.

Overall, whilst we found processes in place for monitoring the deliverables within the IMTP we raised matters relating to the age of some of the performance data,

responsibility for the IMTP targets within divisions and the delivery milestones regarding the Clinical Futures targets.

5. Other Activity

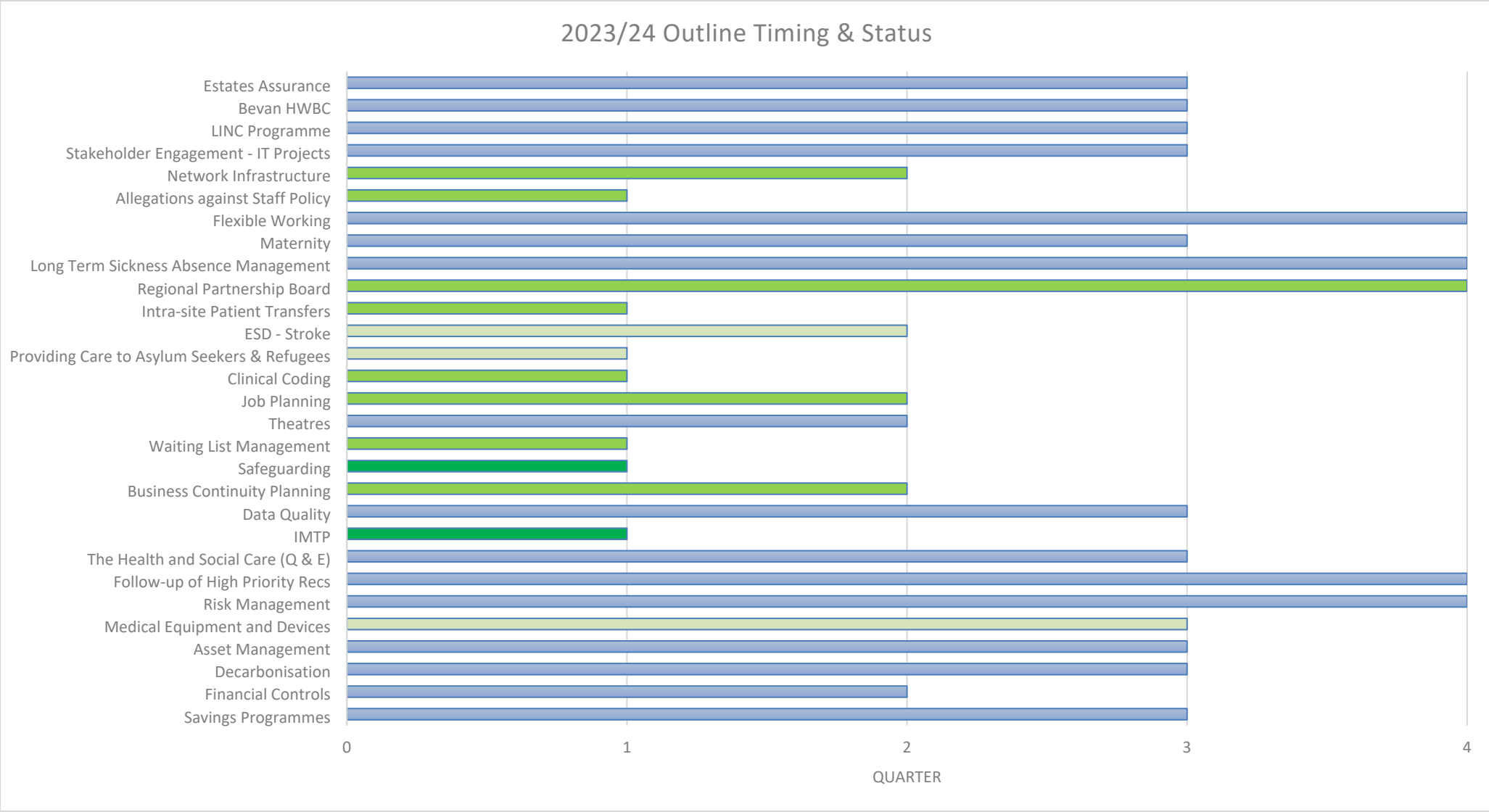
The following meetings have been held/attended during the reporting period:

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

6. Recommendation

The Audit, Risk and Assurance Committee is invited to **note** the above points within the report.

Appendix A: Progress against 2023/24 Internal Audit Plan



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.

Bank Office and Temporary Workers Final Internal Audit Report

August 2023

Aneurin Bevan University Health Board

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

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

Contents

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Executive sign-off:	Sarah Simmonds, Executive director of Workforce
Distribution:	Julie Chappelle, Assistant Director of Workforce
Committee:	Audit, Risk and Assurance Committee

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

Acknowledgement

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

Disclaimer notice - please note

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

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Executive Summary

Purpose

This internal audit has been undertaken to provide an opinion over the Bank Office and Temporary Workers process. We also undertook follow-up audit work over the process for contract and off-contract nursing agency.

Overview

Overall, we found good processes in place within the Bank Office. The controls are well defined and adhered to, but we identified a couple of improvements, including anomalies in the electronic shift and agency timesheet approval.

We completed follow-up work on the recommendations raised within the 2022-23 Use of Off-contract Agency audit. We found improvements had been made with the authorisation process and introduction of new controls. However, we raised an update (matter arising 3) on the testing completed previously over the timeliness of the notification of shifts. This overlapped with our audit work within the Bank Office and thus, is interlinked with audit objective 3.

As the recommendation from the Use of Off-contract Agency is still relevant and tracked on the Audit Recommendation Tracker, we have not raised an additional one. However, we have taken the updated position into account for the assurance rating.

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

Report Classification

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

Assurance summary[1]

	Assurance objectives	Assurance
1	Set-up of new workers	Reasonable
2	Approval of bank / agency shifts	Reasonable
3	Notification of shifts to workers	Limited
4	Payment of bank and agency shifts	Substantial
5	Management of bank/ agency workers	Substantial
6	Follow-up of prior audit recommendations	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	Incomplete TRAC starter task checklist	1	Operating Effectiveness	Medium
2	Electronic shift and agency timesheet approval	2	Operating Effectiveness	Low
3	Ward roster and unfilled shift bank release timeliness[2]	3	Operating Effectiveness	High

[2] This has been raised as a position update on a previously raised recommendation. The original recommendation still requires tracking. Therefore, we have not raised a further recommendation.

1. Introduction

1.1 This internal audit has provided an opinion over the Bank Office and Temporary Workers process and was completed in line with the 2022/23 Internal Audit Plan.

1.2 The review sought to provide Aneurin Bevan University Health Board (the 'Health Board') with assurance that operational procedures and policy have been adhered to.

1.3 Procedures should be in place that provide a structure for the engagement of temporary workers from bank and agencies and are designed in such a way as to minimise the incidence of agency hire. The Health Board maintains a process to ensure the use of agency (on and off-contract) is restricted and is used only when all other alternatives have been considered.

1.4 The Bank Office provides this structured process for appointing bank and agency workers to fill gaps in ward rosters.

1.5 This audit focussed on the key operational arrangements within the Bank Office, to ensure that they are robust and adhered to. It also incorporated follow-up testing on a sample of off-contract agency shifts, to review the progress towards implementing the recommendations of the Use of Off-contract Agency audit, rated limited assurance.

1.6 The high demand for temporary workers following the impact of the Covid-19 pandemic, which continues to place pressure on the Bank Office operations, will be considered within the conclusions raised from our sample testing.

1.7 We previously undertook a review of the Bank Office and Temporary Workers process (entitled 'Review of Bank Office') during 2015/16, which was rated as limited assurance. We also completed follow-up audit work on the same area, with the Bank Office Follow-up, which was rated as substantial assurance.

1.8 The risks considered in the review included:

- insufficient staffing levels on wards, due to inadequate planning;
- increased workforce financial costs;
- a lack of oversight and action taken to minimise the use of off-contract agency;
- inappropriate authorisation over the use of temporary workers for shifts; and
- insufficient oversight / management of bank / temporary workers.

2. Detailed Findings

The table below summarises the recommendations raised by priority rating:

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

Objective 1: setup of bank workers onto appropriate systems, including where applicable, the use of Health Roster / BankStaff systems

2.1 We tested a sample of 20 bank worker new starters to ensure that the set-up control processes were being adhered to. Our sample was taken from candidates recruited between November 2022 and May 2023, who had worked at least one shift.

2.2 We found that the bank workers, worker hire and record set-up follows the Health Board's regular recruitment processes.

2.3 The Trac recruitment system is used to manage and record the appointment of substantive and bank staff. We tested the key controls that are described in the paragraphs below.

2.4 **Employment checks**

The Trac system records in a checklist format a range of employment checks including professional registration, references, visa / work permit indicating for each the status of the check as 'Success', 'Not Started' or 'Not Required'. All checks must be satisfied before a worker can take up and work shifts. Checklists for all staff in our sample were satisfactorily completed.

2.5 **Starter tasks**

Similarly, a checklist operates to record that all starter tasks have been completed before a new worker will be allowed to take up and work shifts. Starter tasks include the issue of information packs or consent forms including bank worker agreement, the European working time directive (EWTD) consent form and the issue of an All Wales Terms of Engagement form. Again, all checks must be satisfied before a worker can take up and work shifts but we noted that, whilst we were assured that the all-Wales terms of engagement form had been issued to the new workers, checklists did not record this for the majority of the staff within our sample (**see Matter Arising 1**).

[3] This has been raised as a position update on a previously raised recommendation. The original recommendation still requires tracking. Therefore, we have not raised a further recommendation.

2.6 **Bank Fast Track Enrolment Payment Instruction Form**

When the recruitment process is complete and all materials have been captured and recruitment checks conducted, a senior officer in the Recruitment Team submits an instruction to payroll to create a worker record in ESR and BankStaff systems. Once complete, the worker can now view and book on to bank shifts. We noted that in all 20 cases these forms had been duly raised and appropriately authorised.

Conclusion:

2.7 Whilst we found good adherence to the established processes, we found one anomaly in our testing, where one step on the checklists was not fully completed. We were informed that the required step of issuing the All Wales Terms of Engagement had been completed, but this had not been recorded as such on the checklist. Overall, we have provided **reasonable assurance** over this area.

Objective 2: approval of bank / agency temporary shifts

2.8 We noted the following process operates for the approval of temporary shifts covered by bank or agency workers:

- Health roster systems identify gaps that need to be filled by bank or agency staff;
- rosters that have been prepared by ward staff are signed off by the assistant divisional nurses;
- unfilled shifts (gaps) are notified to substantive staff who are able to book themselves onto these shifts. These shifts may be offered at enhanced rates through:
  - flexible rewards/ winter incentives;
  - overtime;
  - additional hours;
- shifts that remain unfilled are 'sent to bank' (this must be done by authorised divisional staff). Bank workers are now able to book themselves onto these shifts;
- shifts that remain unfilled, as the date of the shift in question nears, are sent to contract / framework agencies (this is selected by the health roster user in the system and actioned by the Bank Office Team);
- shifts that still remain unfilled after release to contract agencies are then sent to off-contract agencies, following the separate process.

2.9 We tested a sample of 20 worked shifts across the period April 2022 to March 2023, selecting 13 bank and 7 agency workers (to mirror proportions in the full population) and tested the key controls covered in the paragraphs below.

2.10 **Substantive staff approval of worker shifts**

Bank workers no longer complete paper timesheets for their shifts, but agency workers do (see more below where agency shift payment controls are examined).

2.11 All completed shifts, both bank and agency, must be electronically finalised in the BankStaff system by an authorised staff member to record and approve the hours that were worked. To be qualified to do so, the staff finalising the shift must be recorded on the division's ASL listing where permissions, systems access/ financial budgetary levels etc. are recorded. We noted that in two of the 20 shifts in our sample, the substantive staff member electronically finalising the shift was not recorded on the ASL as having that authority (**see Matter Arising 2**). However, they would not be able to finalise the shift electronically, without holding the necessary permissions within BankStaff. Consequently, this is an administrative point.

2.12 **Substantive staff approval of agency timesheets**

Similarly, timesheets of agency workers must be approved by an authorised substantive staff member. We noted that in two cases in the sample the substantive staff member signing the agency workers timesheet was not recorded on the ASL as having that authority (**see Matter Arising 2**). However, we confirmed that one individual was in a position of authority to approve the timesheet (i.e. can approve timesheets). The second within the sample, no longer works for the Health Board, so we have been unable to verify if they held the authority to approve the timesheets.

2.13 For each of the exceptions identified above, relating to timesheets and agency timesheets, we were not able to determine if these individuals hold appropriate authority for the authorisation and thus, an administrative update is required to the ASL.

Conclusion:

2.14 We have raised one matter arising under this objective relating to linked shift and timesheet approvals. Therefore we have provided **reasonable assurance** over this area.

Objective 3: notification of shifts to workers

2.15 We noted the following process operates for the notification of temporary shifts to substantive, bank and agency workers:

- ward rosters are completed for a five week period to a published timetable. Roster approval dates in the timetable are approximately six weeks in advance of the roster start;
- ward staff filling rosters seek to fill as many shifts as possible with substantive staff. This includes offering overtime, additional hours etc. When all available resources have been taken into the plan, a roster is finalised and the unfilled shifts are first 'sent to bank' for filling;
- bank workers have log-ins to the BankStaff system and can book themselves onto vacant shifts;
- unfilled shifts may be incentivised by receiving a flexible reward as the shift date nears;

- when shifts are not filled by bank staff these are released to framework agencies;
- framework agencies have log-ins to the Health Board's BankStaff system and can book their workers onto vacant shifts;
- there are rules around lead times for the release of vacant shifts to bank, and then to agency, including:
  - unfilled shifts should be sent to the Bank Team on the date of the publication of the roster (calendar for the publication of rosters is provided by the E-systems Team); and
  - no shifts should be sent to the agencies to fill until the shifts have been available to bank workers for 28 days (revised March 2023, previously stated at 14 days in rules dated October 2022).

2.16 With our sample of 13 bank and 7 agency shifts we tested the controls outlined above and noted the following:

- the approval dates for the final rosters were all later than the timetable targets: the average slip of final roster approval from the timetable was 16 days.
- unfilled shifts release to bank dates were not prompt (rules indicate that they should be 'sent to bank' on the day of roster final approval), but all were delayed beyond the date of roster approval: the average delay to bank release, following roster final approval was 26 days.

(**see Matter Arising 3**)

Conclusion:

2.17 We have raised matters arising under this objective relating to delayed roster approval and unfilled shift bank release and therefore have provided **limited assurance** over this area.

Objective 4: payments made to bank / temporary workers

2.18 We noted the following process operates for the approval and payment of temporary shifts for bank and agency workers:

- payments for shifts worked and electronically finalised are made to bank workers through the regular Health Board payroll workflows, following electronic finalisation of the shift;
- agency worker timesheets must be approved by divisional staff (e.g. ward senior nurse, ward manager) who are on the ASL listing with that authority permission, and that ward/ cost centre designated;
- agencies submit matched pairs of shift timesheets and invoices for shifts worked by their workers and these are processed and paid accordingly; and
- the Bank Office Team operate a test review of the accuracy and validity of the data in the files they submit for payment processing.

2.19 With our sample of 13 bank and 7 agency shifts we tested the key controls outlined above as follows:

2.20 **Bank shifts**

For each sample bank shift we obtained the data load payment instruction file (prepared by the Bank Office and sent to payroll) in which our sample shift was included. Having done so, we verified the accuracy of the payment instruction for our sample shift by agreeing details of the shift reference, the worker and the hours worked.

2.21 **Agency shifts**

We obtained for each sample agency shift, the data load payment instruction file prepared by the Bank Office Team and sent to Accounts Payable in which our sample shift was included. We verified the accuracy of the payment instruction by agreeing details of the shift reference, the worker and the hours worked. Additionally, in the case of the agency shifts, we verified the evidencing of the checking by a second Bank Office Team member of every 10th payment entry on the data load payment instruction file, evidencing the entries that had been subjected to an independent check of accuracy and detail prior to submission for payment.

2.22 We noted no anomalies or exceptions in the payment instruction files in either bank or agency shift samples.

Conclusion:

2.23 We noted no anomalies or exceptions in the payment process for the sample shifts and therefore have provided **substantial assurance** over this area.

Objective 5: any applicable ongoing management of bank and agency workers

2.24 We noted the following process operates for the notification and investigation of recorded patient safety incidents or complaints where bank or agency staff have been implicated and may be at fault:

- incidents that have taken place across the Health Board are recorded within the Datix database;
- each month new cases posted in the period are reported out of the system for scrutiny by the clinical lead in the Bank Office Team;
- cases involving bank or agency workers are highlighted and shortlisted for examination;
- those of concern and where bank or agency staff involved may be at fault are investigated;
- investigations are conducted involving divisional staff / bank / agency workers;
- outcomes of the investigation are recorded within the Datix case;
- workers may as a result of the outcome of the investigation have their permitted duties adjusted:
  - restrict the duties that the worker will be hired for;
  - arrange that the worker undergo appropriate training or learning to address the issue and prevent recurrence;

- suspend/ exclude the worker from working with the Health Board.
- cases involving agency workers are recorded in a template report submitted monthly to the Health Board's Agency Worker Contract Management Team and where necessary, are taken up with the agencies in question.

2.25 We reviewed the process of reporting agency related cases over four sample months of 2022/23 and examined the materials that documented what had been recorded and actioned.

2.26 We noted that 20 was the average number of agency worker related cases reported across the sample months examined within the audit, and that the actions taken by the Health Board in these cases in aggregate can be summarised as follows:

Action taken	Percentage of cases
Agency Advised	45%
Referred to safeguarding/police	33%
Shifts restricted	21%
Full Investigation in place	1%

Conclusion:

2.27 We have raised no matters arising under this objective and therefore have provided **substantial assurance** over this area.

Objective 6: review of the progress made with the implementation of the recommendations raised previously within the Use of Off-contract Agency audit

2.28 We conducted a follow-up exercise on the recommendations of the previous audit AB-2223-12 Use of Off-contract Agency (Nursing) issued January 2023. This audit raised four recommendations which, with a detailed summary of the progress made in the table below.

2.29 Overall, we found considerable progress has made to address the underlying issues raised within the Use of Off-contract Agency audit. In particular, the evidence for approval and the rationale for use of off-contract agency is readily available, with the necessary approvals in place. There has been a drive to utilise all options prior to utilising off-contract agency (e.g. overtime, bank workers etc.).

2.30 We recognise that rosters can change very suddenly and resource requirements are updated very close to a shift start. However, further work is still required to maximise the timeliness of roster publications and the release of shifts to substantive and bank workers first.

2.31 However, we have seen a significant decrease in the use of off-contract agency since January 2023, which is also significantly lower than the same months in 2022.

2.32 Overall, whilst work is still required to improve the timeliness over the completion of some steps within the revised process, we have confirmed that there is a decreased use of off-contract agency and improved compliance regarding the authorisation process. Furthermore, we have recognised **matter arising three**

within audit objective three. Therefore, we have provided **reasonable assurance** for this objective.

2.33

2022/23 Recommendations	Current Position
1. Policy and procedure document review and ratification	Revised documents have been issued to the business and shared in this audit. This has been **fully implemented**.
2. Compliant escalation evidence	A standard checklist of questions to requestors has been developed. Prior to providing authorisation for off-contract agency shifts, this process is completed by the approver. The approval email is confirmation that all other options have been considered. In most instances (9 of the 10), this was also clearly indicated too within the narrative. We tested a sample of 10 requests and found completed off-contract agency proformas. Whilst these forms were not formally signed off, we found the necessary email authorisation, approving the use of off-contract agency for each of the sample tested. Therefore, alongside the proforma, email authorisation, the checklist of questions and senior approval, we consider the remaining risk to be low. Furthermore, we previously identified the approval of multiple requests within single emails, often totalling tens of shifts, across numerous wards. With the sample tested, this is no longer the case, with the approvals and requests relating to single / few shifts within one area. We consider this recommendation to be sufficiently **implemented**.
3. Unfilled shift escalation timeline	The Resource Bank Rules came into effect in October 2022. The application of the 14 day rule for sending shifts to contract agencies has now been extended to 28 days [introduced in revised bank rules issued January 2023], this is from the point the roster is released. This is to ensure the majority of shifts are issued to substantive and bank workers in the first instance. However, it is acknowledged that rosters are live and will continually change as staff become absent due to a variety of reasons. The Health Board has confirmed its intention to prescribe only the period for which a shift is offered to bank workers first before being released to off-contract agency and that period was stated at 28 days in bank rules issued January 2023. We previously recommended the issue of a guidance document / process, prescribing the number of days. This has now been completed and we consider this recommendation **implemented** (except for the further work required as described in point four below and **matter arising three**).

4. Roster and unfilled shift escalation anomalies	Within the sample tested, we found that the roster actual final approval dates were all later than the timetable target, with an average slip of 16 days. In addition, unfilled shifts release to bank dates were not prompt (rules indicate that they should be 'sent to bank' on the day of roster final approval) but all were delayed beyond that date: average delay to bank release following roster final approval was 26 days. Both of the above points are included within **matter arising three.**

Appendix A: Management Action Plan

Matter arising 1: Incomplete TRAC starter task checklist (Operating Effectiveness)	Impact
We noted a checklist operates to record that all starter tasks have been completed before a new worker will be allowed to take up and work shifts. Starter tasks include issue of information packs or consent forms including bank worker agreement, the European working time directive (EWTD) consent form and the issue of an all Wales terms of engagement form. All checks must be satisfied before a worker can take up and work shifts but we noted that, whilst we were assured that the latter all Wales terms of engagement form had been issued, checklists did not record this for the majority of new starters in our staff sample. We were advised that this is because a backlog has developed and is taking time to clear.	Potential risk that new starters my commence work with gaps in their knowledge of terms, conditions, procedures etc.

Recommendations	Priority
1.1 We recommend that outstanding tasks on the Starter Task checklist are completed at the earliest available opportunity and that going forward, these checklists are fully completed before new workers are allowed to work their first shift.	Medium

Management Responses	Target Date	Responsible Officer
1.1 Agree recommendation A process review took place across internal and external appointments to bank with an implementation date of 24.4.2023 to ensure that all check lists are on the TRAC system. A plan is in place to quality check the older records in TRAC and ESR in priority order (oldest records first followed by those that have already started).	1st October 2023	Sian Bigmore, Recruitment Service Improvement Manager

Matter arising 2: Electronic shift and agency timesheet approval (Operating Effectiveness)	Impact
All completed shifts, both bank and agency, must be electronically finalised in the BankStaff system by an authorised substantive staff member when they have been worked and similarly, timesheets of agency workers must be approved by an authorised substantive staff member to record and approve the hours that were worked. Authority of the approver is evidenced in the ASL listing. We noted that in 2 of the 20 shifts in our sample, the substantive staff member electronically finalising the shift was not recorded on the ASL as having that authority. However, they would not be able to finalise the shift electronically, without holding the necessary permissions within BankStaff. Consequently, this is an administrative point. We also noted that in 2 cases in the 7 agency shifts in our sample, the substantive staff member signing the agency workers timesheet was not recorded on the ASL as having that authority. However, we confirmed that one individual was in a position of authority to approve the timesheet (i.e. can approve timesheets). The second within the sample, no longer works for the Health Board, so we have been unable to verify if they held the authority to approve the timesheets.	Potential risk that shifts are approved by unauthorised staff.

Recommendations	Priority
2.1 We recommend that mismatches between the BankStaff system settings/ permissions and ASL listings are identified, examined and addressed.	Low

Management Responses	Target Date	Responsible Officer
2.1 Divisional Nursing management will send out a communication to all ward managers to remind them of the requirement to ensure all staff required to electronically finalise shifts on HealthRoster / BankStaff have completed the relevant forms to be added onto the ASL.	30th August 2023	Linda Alexander, Deputy Director of Nursing

Matter arising 3: Ward roster and unfilled shift bank release timeliness (Operating Effectiveness)	Impact
This matter arising was first raised within the Use of Off-contract Agency audit and has been included on the Audit Recommendation Tracker (the 'Tracker'). This is a position update and not a new recommendation. However, the status on the Tracker should be reviewed, to ensure it still remains applicable. We confirmed that the actual final approval dates of the rosters, in which our sample shifts appeared, were later than the roster timetable target (average slippage of the final roster approval from the timetable was 16 days). Furthermore, the release of unfilled shifts to the bank was not prompt. For the latter, rules indicate that they should be 'sent to bank' on the day of roster final approval, but all were delayed beyond that date (average delay to bank release following roster final approval was 26 days).	Increased risk that unfilled shifts are not filled by bank workers resulting in more expensive contract options being utilised.

Recommendations	Priority
3.1 There is no further recommendation to raise. However, for completeness, the previous recommendation is detailed below. *We recommend that the Health Board monitor and address any compliance issues with the current process in use. Where anomalies are identified going forward, these should be investigated and training provided to assist with the embedding of the controls. Furthermore,* • *rosters should be prepared in a timely manner; and* • *shifts should be released to the bank, contract and off-contract agencies at the appropriate time, with sufficient time to ensure all alternative options are considered.*	High

Management Responses	Target Date	Responsible Officer
Divisional Nursing management will send out a communication to all Senior Nurses to remind them of the requirement to ensure all rosters are approved within the requirement timetable and to remind the nurses to send all Bank shifts to Bank at the earliest opportunity in the roster period. This will be monitored in the bi-weekly meetings with Senior Nursing managers.	30th August 2023	Linda Alexander, Deputy Director of Nursing

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.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

IMTP
Internal Audit Report
August 2023

Aneurin Bevan University Health Board

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

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

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Executive sign-off:	Hannah Evans, Director of Strategy, Planning and Partnerships
Distribution:	Christopher Dawson-Morris, Director of Planning & Performance Trish Chalk, Assistant Director of ABCi
Committee:	Audit, Risk and Assurance Committee

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

Acknowledgement

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

Executive Summary

Purpose

This internal audit has been undertaken to provide an opinion over the controls to ensure the delivery of the IMTP / strategic objectives.

Overview

Overall, whilst we found processes in place for monitoring the deliverables within the IMTP we raised matters relating to the age of some of the performance data, responsibility for the IMTP targets within divisions and the delivery milestones regarding the Clinical Futures targets.

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

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	⇔ Reasonable 2017/18

Assurance summary[1]

	Assurance objectives	Assurance
1	Monitoring IMTP deliverables progress	Reasonable
2	Internal /external oversight reporting	Substantial
3	Capture and management of actions	Substantial
4	Delivery by the divisions and services	Reasonable

Matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	IMTP life-course priority progress status reporting	1	Design	Low
2	Clinical Futures Programme deliverables milestones	1	Design	Medium
3	Monitoring IMTP priorities delivery by the divisions	4	Operating Effectiveness	Medium

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

1. Introduction

1.1 This internal audit has provided an opinion over Aneurin Bevan University Health Board's (the 'Health Board') processes for monitoring and reporting on its delivery of its Integrated Medium Term Plan (IMTP) priorities.

1.2 The Health Board's objective is population health and the three year IMTP is a plan of activity designed to maximise this within the constraints of the resources available.

1.3 The IMTP includes patient demand across a range of specialist services and sets these against the Health Board's capacity to deliver them. A submission to the Welsh Government over the levels of proposed activity is completed on a regular basis.

1.4 As well as a full organisational business plan, the IMTP focusses on improvement ambitions and development initiatives led by the Ministerial Priorities published each year by the Welsh Government. Health boards are mandated to address these areas as priorities and within the life time of the plan, to report regularly on progress to their delivery.

1.5 We previously undertook a review of the Health Board's IMTP process during 2017/18 (rated 'reasonable assurance') focussed on two areas: the effectiveness of the divisional planning arrangements in relation to service, staffing and finance; secondly, on whether performance management arrangements were effective in delivering the IMTP, primarily through the delivery of Service Change Plans.

1.6 Implementation of the IMTP deliverables is monitored through a new Outcomes Framework and it is this aspect on which this audit focussed.

1.7 The risks considered in this review included:

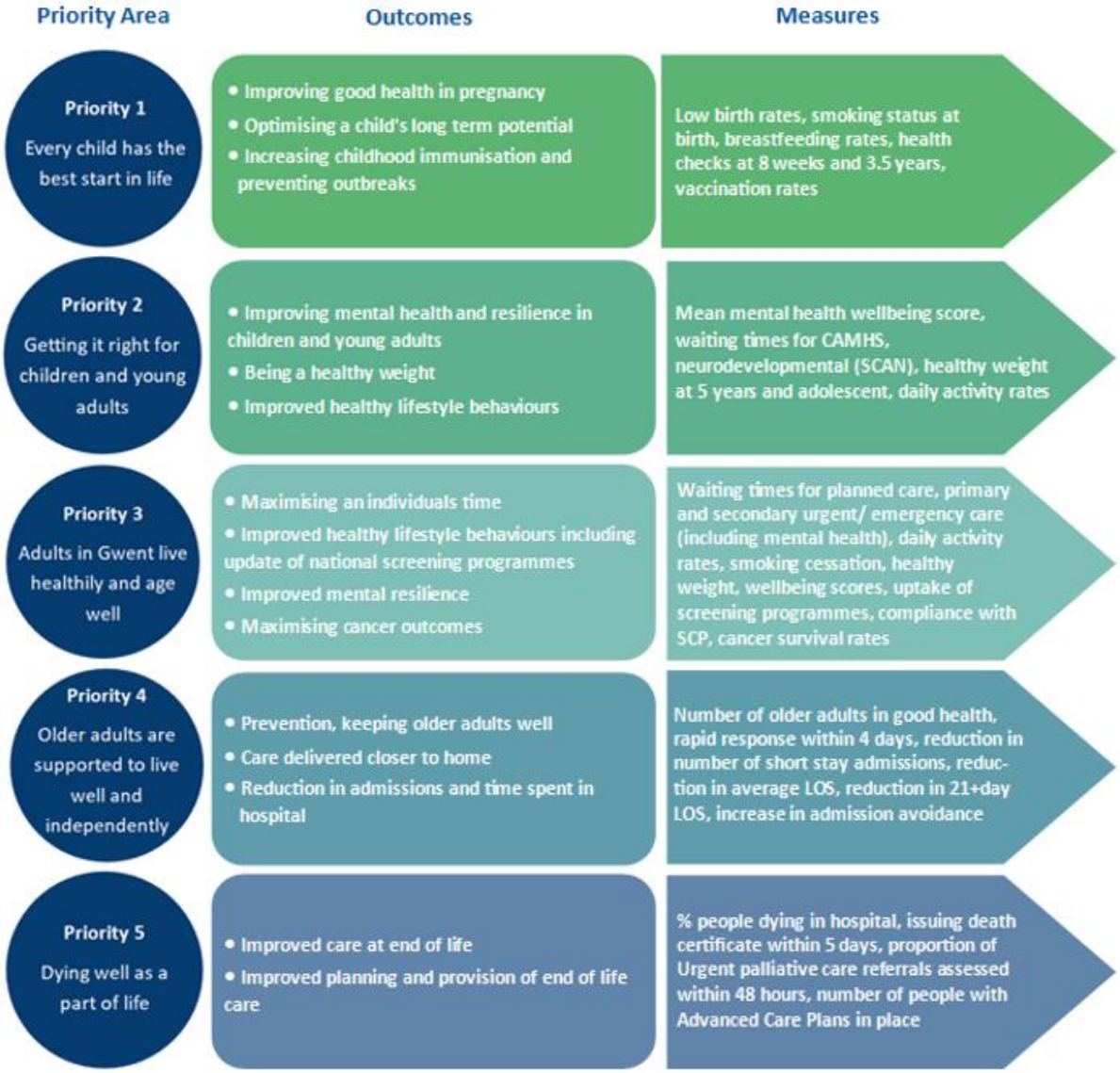
- Failure to meet statutory requirements, including financial deliverables.
- Resources are focussed on priorities outside of strategic objectives.
- IMTP deliverables are not implemented.
- Inappropriate governance arrangements.
- Patient care / service is not improved.

2. Detailed Findings

Objective 1: Robust processes are in place for the monitoring and recording of the progress made against the key commitments within the IMTP

2.1 We sought to establish the effectiveness of the process the Health Board adopts for monitoring and recording its progress against its IMTP population health targets. The Health Board uses an outcomes based reporting model to seek to understand the impact of their programmes. Detailed below is a chart of the key priority areas and how the Health Board is monitoring delivery progress.

2.2 Life-course linked priorities



The chart above illustrates the Life-course priority areas, improvement ambitions and accompanying measures

The Health Board has adopted the life-course structure detailed above for the monitoring of its IMTP improvement ambitions and has defined key outcomes and measures accordingly.

2.3 Metrics selected to best represent progress of each of the life-courses are linked with appropriate measures and these are monitored and reported to relevant committees, the Board and the Welsh Government in the quarterly Outcome and Performance Report.

2.4 In this report, the baseline, target and latest values for outcome measures are used to provide the trajectory and current status of the measure.

2.5 However, we noted in our test of a sample of measures that, where linked to long life cycle studies, data lag was in some cases significant.

2.6 We noted the following when reviewing the progress assessments of a sample of 10 of the 41 performance indicators in the 2023/24 Q1 Outcome and Performance Report:

- the age of the data values used in the evaluation ranged between 0 and 13 quarters; and
- because of the data age, three of the four measures in the sample which were assessed as of 'improved' status are unreliable and may be overstating actual progress.

(see **Matter arising 1**).

2.7 **Clinical Futures transformation programmes**

Clinical Futures programmes, which are major development areas for the Health Board, feature prominently in the IMTP submission, report key achievements each quarter and the focus for upcoming quarters. However, these updates do not provide in their account of achievements any reference to the original target deliverables or dates. Consequently, these do not convey whether deliverables are on track (**see Matter arising 2**).

2.8 **Deliverables linked to Ministerial Priorities**

Commitments to deliver against the IMTP targets that emanate from the Ministerial Priorities are set out in a document which forms part of the Health Board's IMTP submission. An assessment is recorded each quarter in a tracking document that captures actual progress of these deliverables against the original planned targets. This assessment is then included in the quarterly update of progress in the Outcome and Performance Report, which is shared with the Welsh Government.

2.9 We noted that in the quarter one 2023/24 review of the Ministerial Priorities Plan, which examined the status of all 224 actions to deliver the plan milestones, 164 were assessed as 'Complete/On schedule', 50 were 'Off track within tolerance' and 10 classified as 'Significantly off track'.

2.10 **Review of performance against minimum data set submitted forecasts**

The Health Board submits its forecast activity levels, in terms of expected patient numbers, in the Welsh Government template, 'Minimum Data Set' (MDS) data spreadsheet as part of its IMTP submission. Actual activity levels are monitored and these are included in the quarterly Outcome and Performance Report where a review of actual levels achieved against these predictions is provided. Forecasts for future periods may as a result be adjusted and in earlier years, the MDS was refreshed and re-submitted to the Welsh Government, although health boards have not yet been advised whether this will be required for 2023/24.

2.11 **Progress of key IMTP enablers**

The progress reporting of the life-course priorities, Clinical Futures programmes and Ministerial Priority deliverables in the quarterly report may refer to workforce and finance assumptions, which underpinned the original IMTP predictions, particularly if actual levels are at significant variance to plan forecast. Finance and Workforce both monitor their resource actual levels each month against forecasts that were part of the IMTP submission and report these to their respective oversight committees.

Conclusion:

2.12 We have raised two matters arising under this objective relating to the IMTP life-course priority and Clinical Future programme outcome measures and therefore have provided **reasonable assurance** over this area.

Objective 2: Appropriate performance reporting and escalation processes to relevant groups / committees and the Welsh Government are embedded

2.13 We sought to establish the scope, effectiveness and reliability of performance reporting to internal and external oversight bodies with an emphasis on IMTP deliverables.

2.14 The Health Board has developed an organisational Outcomes Framework which brings together in the Outcome and Performance quarterly report progress updates across the key IMTP elements, previously described under audit objective one above and listed below:

- the life-course linked priority outcome measures;
- Clinical Futures programmes;
- key milestones and actions against the ministerial priorities; and
- planning scenarios as set out in the MDS of the IMTP.

2.15 Sources for each of these key elements of the progress report are as set out below:

IMTP Deliverable element	**Source of materials used for Outcome and Performance report updates**
Priorities 1-5 linked to life-courses	Welsh Government statistics, some internal data from the Health Board's integrated Performance Report (IPR) tool.
Clinical Futures programme – 8 priority programmes	Monthly highlight reports from the individual programmes to the Clinical Futures Programme Board.
Ministerial priorities	Ministerial Priorities quarterly report framework.
MDS	Quarterly MDS report. Quarterly refresh of MDS.

2.16 This is supplemented / supported through the following elements of the Health Board's existing reporting framework:

Domain	Reporting/ modelling	Board / Committee
Activity	Monthly Report, Quarterly Refresh Of MDS	Board
Utilisation	Dynamic Planning Tool	Strategy, Planning Partnerships & Well-Being Group/ Board
Workforce	Monthly Reporting	People & Culture Committee
Finance	Month End Reporting	Audit Finance & Risk Committee
Quality and Experience	QPS report/ Clinical Audit	Patient Quality, Safety & Outcomes Committee

2.17 The Outcome and Performance quarterly report is seen widely both within and external to the Health Board as follows:

- Board;
- Executive Team;
- Population and Planning Committee;
- Finance and Performance Committee; and
- Welsh Government.

2.18 IMTP progress is also discussed between the Executive Team and Welsh Government at their Joint Executive Team (JET) and at regular meetings with the Delivery Unit.

Conclusion:

2.19 We noted no anomalies or exceptions in the performance reporting and escalation process and therefore have provided **substantial assurance** over this area.

Objective 3: Actions / issues arising are managed appropriately and in a timely manner

2.20 We sought to establish the processes through which issues arising from IMTP deliverables implementation are identified and addressed and having done so, determine whether these are addressed promptly.

2.21 We recorded under objective two the monitoring activity completed by different committees / teams within the Health Board.

2.22 We noted remedial actions for underperforming targets are referenced in the quarterly Outcome and Performance Report, which is presented to the respective committees. However, they are not recorded in detail and the committees who review these reports do not themselves assign actions to address targets that are not being achieved.

2.23 Under this objective we reviewed the action logs of the following covering the period Q4 2022/23 to Q1 2023/24:

- Board;
- Executive Team;
- Population and Planning Committee;
- Finance and Performance Committee; and
- Clinical Futures Programme Board.

2.24 The logs cover the broader business of the bodies, but in several cases we noted references to IMTP related issues.

2.25 Action logs of the Board, committees and Executive Team are built on a common template, are of a conventional format (action description, individual tasked, target date, status comment) and are managed through the respective meetings of the bodies (the Clinical Futures Programme Board record actions within the meeting minutes rather than in a formal action log).

2.26 We noted the following minor points related to IMTP linked actions in the Board and committee action logs we examined:

- action reference 3011/17 in Board minutes November 2022 does not include a target date;
- two actions in the Executive Team action log dated December 2022 and March 2023, respectively related to the 2023-26 IMTP do not record a target date or status description.

2.27 Actions in respect of IMTP deliverables arising from the monthly divisional assurance meetings are examined under audit objective 4 below.

Conclusion:

2.28 We noted no anomalies or exceptions in the performance reporting and escalation process and therefore have provided **substantial assurance** over this area.

Objective 4: Effective processes are in place within the divisions for monitoring and reporting the delivery against the key objectives within their agreed IMTP

2.29 We sought to establish how divisions determine and plan their IMTP priorities and how delivery of these is monitored.

2.30 **Preparing divisional plans**

We note that a collaborative planning process operates within the Health Board, where the Central Planning Team work with the specialities, services and divisions to identify and plan into the latter's activity plans the work they will undertake to deliver the Health Board's IMTP priorities.

2.31 As part of the planning process, specialities, services and divisions provide a forecast of their predicted service levels targets (e.g. patient volumes, treatment timescales).

2.32 Planning meetings take place where these are challenged, refined and prioritised. Meetings are cross-divisional where there are dependencies. Final meetings are led by the Chief Operating Officer and bring together all divisions in a single collaborative forum.

2.33 Agreed targets are provided to the Welsh Government as part of the MDS.

2.34 Divisions are not mandated to produce and submit to the Central Planning Team a divisional plan in a particular format. Rather the IMTP planning approach is about building realistic and deliverable activity profiles, which are owned and delivered by the divisions that work directly with patients and communities.

2.35 From the collaborative process, each division emerges from the annual planning cycle with a business plan reflecting their agreed service priorities. This plan aligns with the Health Board's targets and those that they will follow over the next period.

2.36 **Monitoring divisional plan delivery, including IMTP priorities**

Monitoring of delivery is through multi-disciplinary monthly Divisional Assurance Meetings led by the Chief Operating Officer.

2.37 These regular operational meetings, which include business partners of Planning, Workforce and Finance, cover the full range of activity including a progress review of the IMTP priorities being delivered.

2.38 The results of these reviews may prompt actions where issues are identified with progress, but these are not directly used to record the status of the IMTP outcomes tables in the quarterly Outcome and Performance reports. We were unable to establish whether divisional review assessments and the outcome measure values that are posted in these reports (**see Matter Arising 1**) are checked for alignment.

2.39 With the example divisional assurance meeting materials provided by the eight divisions, we noted that in only three of these were IMTP priorities directly referenced in the review documents. As a result, we were unable to evidence the divisional IMTP delivery review process in the majority of divisions (**see Matter Arising 3**). That said, we acknowledge that in some cases, subjects of the performance updates may be linked to the IMTP priorities.

2.40 In all eight cases we noted Workforce and Finance updates were included in the divisional assurance meeting review documents.

Conclusion:

2.41 We have raised a finding on the low level of evidence of delivery review of IMTP priorities by the divisions and therefore have provided **reasonable assurance** over this area.

Appendix A: Management Action Plan

Matter arising 1: IMTP life-course priority progress status reporting (Design)	Impact
We noted the following when reviewing the progress assessments of a sample of 10 of the 41 performance indicators in the 2023/24 Q1 Outcome and Performance report: • the age of the data values used in the evaluation ranged between 0 and 13 quarters; and • due to the data age, three of the four measures in the sample which were assessed as of 'improved' status are unreliable and may be overstating actual progress.	Potential risk that the progress status values in the outcome tables are mis-stated.

Recommendations	Priority
1.1 We recommend that for accuracy, the assignment of outcome measure progress status values (i.e. 'improved', 'similar', 'deteriorated') take into account the age of the latest data on which that measure is being assessed.	Low

Management Responses	Target Date	Responsible Officer
1.1 Accept recommendation At the end of the 22/23 IMTP cycle the Outcome Framework and measures were reviewed with the Executive and Board. The purpose was to review the impact of the Framework, and assess the quality of the information included through the measures. The Priority 2 and Priority 4 measures were highlighted as needing to be reviewed and amended due to the age of the data and availability. These have been updated in Q1, and the reviewed report will run in Q2 with the new measures. The next annual review will be in Q4.	Q2 updated measures. Q4 re - review	Director of Strategy, Planning and Partnerships

Matter arising 2: Clinical Futures Programme deliverables milestones (Design)	Impact
Clinical Futures programmes, which are major development areas for the Health Board and feature prominently in the Health Board's IMTP submission, report key achievements each quarter and their focus for the next in highlight reports to the Clinical Futures Programme Board. However, we noted that these updates do not provide in their account of achievements any reference to original target deliverables or dates and therefore, do not convey whether or not deliverables are on or off track.	Potential risk that Clinical Futures programme deliverables slippage goes undetected

Recommendations		Priority
2.1	We recommend that quarterly IMTP Outcome reports include progress against original targets in their update on Clinical Futures Programme deliverables status.	Medium

Management Responses		Target Date	Responsible Officer
2.1	Accept recommendation The Clinical Futures reports have been redesigned and a new reporting process put in place. The changes will provide the required information to include in the Outcome report as recommended.	Q2	Director of Strategy, Planning and Partnerships

Matter arising 3: Monitoring IMTP priorities delivery by the divisions (Operation)	Impact
We were advised that multi-disciplinary IMTP progress reviews are incorporated within the monthly divisional assurance meetings and captured through the quarterly Outcome and Performance reports and the Divisional Assurance processes led by the Chief Operating Officer. However, with the example divisional assurance meeting materials provided by the eight divisions, we noted that in only three of these were IMTP priorities directly referenced in the review documents. As a result, we were unable to evidence the divisional IMTP delivery review process in the majority of divisions. That said, we acknowledge that in some cases, subjects of the performance updates given on the services and specialities activity levels and progress reports on improvement initiatives in the period of review which are recorded in the meeting materials under various headings may be linked to IMTP priorities.	Potential risk that failure by divisions to reach IMTP deliverable targets goes undetected.

Recommendations	Priority
3.1 We recommend that materials of each monthly divisional assurance meeting evidence the review of IMTP deliverables, record the progress of these in the period and record their current status.	Medium

Management Responses	Target Date	Responsible Officer
3.1 Accept Recommendation A new performance Management and Accountability Framework is currently being engaged upon and due for Board sign off in Q2. This framework will tighten up the requirement of the Assurance reviews and standardise inputs and outputs which will include key IMTP commitments. The framework will also include a framework for escalation.	Q2	Director of Strategy, Planning and Partnerships

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.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Safeguarding
Internal Audit Report
September 2023

Aneurin Bevan University Health Board

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

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

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Executive sign-off:	Jennifer Winslade, Executive Director of Nursing Tracey Partridge Wilson, Assistant Director of Nursing
Distribution:	Howard Stanley, Head of Safeguarding
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.

Executive Summary

Purpose

To review the arrangements in place to ensure that the Health Board discharges its statutory responsibilities for safeguarding.

Overview

We have issued reasonable assurance on this area.

This audit focused on the role of the corporate safeguarding team and how they ensure the arrangements in place across the Health Board meet the statutory requirements. We reviewed the main elements of safeguarding and the different processes in place for both adult and children safeguarding. We found the corporate safeguarding team very focused and knowledgeable on the different processes and work hard to ensure any allegation is actioned appropriately.

The matters requiring management attention include:

- The location and completion of the Duty to Report (DTR) form which is a fundamental form in the process of reporting safeguarding concerns for both adult and children. Furthermore, ensuring staff complete the form within 24 hours.
- Ensuring actions within case files are updated or completed regularly so cases can be closed appropriately and in a timely manner.
- Ensuring the Delivery Plan for completing Level Three training is appropriately prioritising relevant staff groups, including the overall delivery volume.

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

Report Opinion

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	 2020/21

Assurance summary[1]

Objectives		Assurance
1	Policies, procedures and legislation	Reasonable
2	Multi-agency cooperation	Substantial
3	Training and support	Reasonable
4	Governance arrangements	Substantial

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

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	Policies, Procedures and legislation (Progress of actions)	1	Operation	Medium
2	Training and Support	3	Design	Medium

1. Introduction

1.1 The review of Safeguarding was completed in line with the 2023/24 Internal Audit Plan. Aneurin Bevan University Health Board (the 'Health Board') has a statutory duty to safeguard adults and children at risk and to promote their well-being.

1.2 By working in partnership with other statutory agencies, professionals, the third sector and the wider community the Health Board works to meet its obligations in relation to safeguarding and protecting children and adults at risk from harm. All employees within the Health Board have a responsibility to ensure any child or adult, who may be at risk of harm in contact with the Health Board directly or indirectly is safeguarded and protected from harm.

1.3 The key risks considered in this review were:

- Non-compliance with applicable legislation, guidance and policy, resulting in patient harm.
- Insufficient communication and cooperation with relevant multi agencies.
- A lack of training and development of staff to ensure effective and safe working.
- Safeguarding issues and concerns are not investigated and managed appropriately leading to inappropriate/insufficient governance arrangements regarding safeguarding throughout the Health Board.

2. Detailed Audit Findings

Objective 1: There are policies and procedures that conform to legislation and guidance – including Disclosure Barring Service (DBS) controls for staff and volunteers.

2.1 There is extensive safeguarding legislation and guidance, with the Social Services and Well-Being (Wales) Act 2014 being key. Alongside this, there is 'The Wales Safeguarding Procedures' and these guide organisations in safeguarding practice. The Health Board captures any new legislation or guidance through attendance at the All Wales Safeguarding Board (the 'Safeguarding Board'). This is a joint forum involving different agencies, including health and social services, the main aim of the Safeguarding Board is to ensure best practice and partnership working exists and all relevant legislation is adhered to. New guidance and legislation are circulated to the Safeguarding Team, divisions and incorporated into safeguarding training.

2.2 Alongside this, the Health Board has its own local policies and standard operating procedures (SOPs). These are controlled via SharePoint. We reviewed a selection of policies and SOPs and found they were all appropriate and conformed to legislation. However, some were not complete, with the author not listed and / or documents not dated.

2.3 Regarding the Disclosure and Barring Service (DBS), the Health Board administers this in conjunction with Recruitment Services, alongside the TRAC process when recruiting individuals. Managers identify if a DBS is required for the new employee or volunteer. We were informed that work is underway in redrafting the local DBS policy.

2.4 Both adult and child databases / cases are housed on a Microsoft 365 list application, within SharePoint and access is only allowed to members of the Safeguarding Team. As part of the safeguarding process a Duty to Report (DTR) form is required to be completed for any adult and / or children safeguarding concerns or allegations within 24 hours.

2.5 These forms are hosted on the Health Board's SharePoint safeguarding page, but we found they were not easy to locate, with staff often saving local copies of the forms. When we tested twelve DTRs, we found two instances (both adults) where the DTR form was not completed within 24 hours, which is a statutory requirement. In one instance, the referral had been completed via Datix (within 24 hours) and the second example was reported late by four days (upon investigation by staff this was determined not to be a safeguarding issue). This exception links closely with the conclusion regarding training within audit objective four.

2.6 As well as the reporting of safeguarding for adults and children there is also a practitioners' concern database, which is for allegations against members of staff regarding safeguarding matters. For the processes mentioned, there is a reliance on safeguarding staff to ensure cases are updated regularly, information completed and closed off when appropriate. There is a concern that this sometimes may not always be completed in a timely manner.

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

Conclusion:

2.7 We confirmed that there are policies and procedures in place which conform to legislation and guidance, however there are instances where local policies and SOPs are not complete or up to date and these require attention. We found that the completion of DTR forms is not always completed in a timely manner. There is a reliance on safeguarding staff to regularly update cases so they are closed when appropriate and in a timely manner, the concern is that some cases may be kept open unnecessarily. Therefore, we have provided **reasonable assurance** for this objective.

Objective 2: Conformation of multi-agency cooperation in place and this is working in accordance with legislation.

2.8 The Corporate Safeguarding Team provides expert advice, guidance and support to the Divisions. We were able to observe daily strategy discussions taking place with relevant agencies when appropriate to discuss implementing safeguarding steps going forward.

2.9 We reviewed minutes from different forums, including the Joint Gwent Safeguarding Board and the NHS Wales Safeguarding Network. We confirmed

detailed guidance and legislation discussions taking place and updates on adult and child practice reviews.

2.10 We confirmed multiple, relevant agencies attend these meetings alongside NHS Organisations and other agencies such probation, social services and Gwent Drug and Alcohol Service (GDAS).

2.11 Alongside multi-agency meetings there are also Health Board focused Safeguarding meetings taking place. An example of this is the Safeguarding Committee. This is the forum where Divisions attend and any information or guidance from multi-agency meetings are shared along with any risks or internal issues that staff need to be aware of.

Conclusion:

2.12 There is strong multi-agency working and cooperation happening regarding safeguarding matters. Therefore, we have provided **substantial assurance** for this objective.

Objective 3: Staff have received adequate training and support in relation to the protection of children and adults at risk, this to include the sharing of good practice.

2.13 Safeguarding training is a key control for ensuring staff are aware of what their responsibility for any adult or child, who may be at risk of harm in contact with the Health Board directly or indirectly is safeguarded and protected. There are intercollegiate documents for adults and children that sets out the competencies that all staff should have, to fulfil their role.

2.14 There are three levels of training for safeguarding for both adults and children. It is mandatory for all Health Board staff to have level one in adult and children and level two in adult and children is for patient facing staff. The required compliance level for both levels is at least 85%. The current compliance rate is 84% for both levels.

2.15 Level three training focuses on professionals who contribute towards assessing, planning, interviewing or evaluating the needs of a child or adult with safeguarding concerns. The level three training requires eight hours of training and delivery by the Safeguarding Team. The training is aimed at staff that are involved with high level safeguarding responsibilities (e.g. policy making, investigations etc.). Whilst the number of associated staff is expected to be relatively low, the completion of the module has been set as a requirement for the majority of staff within the Health Board. It is expected to take up to three years to fully achieve the required compliance level. An SBAR was presented to the Executive team in December 2022 outlining the requirements and risks, which are being managed via the risk management process.

2.16 However, key risks regarding safeguarding are covered in levels one and two training for both adult and children.

2.17 As at May 2023 the Safeguarding Committee reported 11,500 staff requiring level three training. As at June 2023, 95 and 155 people have been trained in level three

adult and children safeguarding respectively. As such, whilst the Health Board is demonstrating an ambitious delivery roll-out, it may wish to review the current profile, to ensure all priority areas are fully compliant.

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

Conclusion:

2.18 Training in safeguarding is important to assist staff in recognising if children or adults are at risk. We recognise that a long-term training recovery plan is being implemented, which is adjusted for current operational risks, but the Health Board should ensure all key areas are being targeted appropriately. Therefore, we have provided **reasonable assurance** for this objective.

Objective 4: Governance arrangements exist to manage safeguarding issues, allegations and concerns as well as there being a clear strategy in place.

2.19 The Corporate Safeguarding Team escalate concerns quickly. The governance arrangements in place are robust and within our testing we found that the team process safeguarding issues, allegations or concerns in a timely manner.

2.20 There are monthly team meetings, and these are used to discuss any changes in legislation, issues or concerns and guest speakers are invited for part of the meetings to help with training, for example on information governance matters. The meetings are also used for well-being purposes. The Safeguarding Committee and Safeguarding Strategy for 2022-25 provides strategic oversight and direction for safeguarding across all services.

2.21 Since 2018 a Safeguarding Maturity Matrix (the 'Matrix') has been in place, and this is a quality assurance tool that all health boards and trusts in Wales submit to the Welsh Government on a yearly basis. The five standards within the Matrix are: governance and right based approach, safe care, adverse childhood experiences (ACE) informed, learning culture and multi-agency partnership working. The standards are utilised by organisations to self-assess themselves, with the latest submission for 2021-22 scoring the team favourably in most of the standards. However, the main areas for improvement that were recorded were primarily related to training throughout the Health Board. The submissions are peer reviewed and in 2021 the Health Board was paired with Velindre University NHS Trust.

Conclusion:

2.22 There are robust governance arrangements in place which ensure the Corporate Safeguarding Team manage all safeguarding issues, allegations and concerns appropriately with a clear strategic approach.

2.23 Therefore, we have provided **substantial assurance** for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Policies, Procedures and Legislation (Operation)	**Impact**
Policies and Standing Operating Procedures (SOPs) Emphasis is placed on the Wales Safeguarding Procedures which guide safeguarding practice for all those employed in the Health Board, which apply to all practitioners, managers and volunteers working with adults and children. Alongside this, the Corporate Safeguarding Team have SOPs and local policies in place to guide staff at a local level. These are managed on SharePoint. We reviewed eight of the ten SOPs in place and two policies, and found the following: • authors are not always documented, or the Health Board's template is not adhered to (five instances); and • documents are not always dated or are out of date (six instances – with one being out of date an all-Wales policy). Regarding the Disclosure and Barring Service (DBS), the Health Board administers this in conjunction with Recruitment Services, alongside the TRAC process when recruiting individuals. We were unable to locate the Health Board's local DBS policy and workforce informed us that they are in the process of redrafting a new policy. **DTR Form** The completion of a Duty to Report (DTR) form is a key part of the process for both adult and children safeguarding requirements and must be submitted within 24 hours where there is a safeguarding concern. The form is hosted on the adult and children's safeguarding SharePoint page; however, they are not clearly signposted, with multiple links included and a redirection to an external website. When we completed testing on 12 referrals, we found two adult cases had not completed the DTR form within the 24-hour time frame and thus, were not compliant with the statutory requirement.	Potential risk of: • staff referring to out of date policies and SOPs and not the correct ones. • staff not filling in DTR forms as they are unable to locate them. • safeguarding information on case files not being completed in a timely manner and not being closed off when necessary.

Progress of actions

There is a reliance on safeguarding staff to review and ensure case files are up to date, actions completed and closed when necessary. This is also the case with the practitioner concerns list / database. We were informed that the main reason for this is the dependency on other agencies sharing the relevant information and thus must be monitored regularly to be effective.

Recommendations		Priority
1.1a	The Corporate Safeguarding Team should review all policies and SOPs to ensure they are in date, adhere to the Health Board's template and comply with the necessary statutory requirements.	**Low**
1.1b	The DTR forms should be positioned more clearly on the respective SharePoint safeguarding pages so staff can locate them quickly.	**Low**
1.2	The Corporate Safeguarding Team should remind relevant staff of the requirements for completing a Duty to Report form and review mechanisms to ensure safeguarding and practitioner concerns are regularly monitored, reviewed and updated and closed off when appropriate.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1.1a	The Corporate Safeguarding Team will review all policies and SOP's in line with this recommendation.	31/12/2023	Head of Safeguarding
1.1b	The DTR Forms will be positioned to the top of the SharePoint Safeguarding Page, as two clear buttons, to enable staff to locate them easily.	30/09/2023	Senior Nurse Safeguarding

1.2	Level three training will reiterate the importance of timely reporting. Systems will be put in place to ensure a monthly management review to ensure that cases are reviewed, updated and closed appropriately.	31/12/2023	Senior Nurse Safeguarding

Matter Arising 2: Training and Support (Design)	**Impact**
There are processes in place for adult and children safeguarding requirements and these documents outline the competencies that all staff should have. These are as follows: • Level One - mandatory for all professionals that work in the Health Board. • Level Two - mandatory for professionals who have contact with patients. • Level Three - training for professionals who have a role in assessing, planning, interviewing or evaluating the needs of a child or adult with safeguarding concerns. Whilst we were informed that level three training was mandated by the Welsh Government in November 2022, there are different interpretations of how this is applied. The Safeguarding Team, who deliver this training and other selected individuals directly involved with assessing / evaluating the needs of a child or adult with safeguarding concerns, would be expected to undertake this training. However, the Health Board has extended this requirement to the majority of staff. There is a significant time investment required to complete the training and thus, the delivery across the Health Board has been on a phased approach. The Executive Team has approved the proposed approach and due to patient safety pressures, this has continually been adjusted. Currently, the Health Board is managing the risk via its internal risk management processes. Overall, we considered the mitigation of the primary safeguarding risks through the training programme and were satisfied that Level One and Level Two meets this requirement. The completion rate as at August 2023 is 84% for both levels, comparable to the KPI target of 85%, but still short of the 95% target set within the original paper agreed with the Executive Team. The Safeguarding Committee, in May 2023, documented that a scoping exercise was completed as part of the training recovery plan to find out how many staff require the level three training. The results were as follows: • Bands 6 & 7 Nursing and Midwifery and other staff groups = 4,900 • Bands 5 & 7 Nursing and Midwifery and other staff groups = 6,600	Potential risk of: • patient harm if staff are not adequately trained in safeguarding. • potential litigation for failing in duty to protect service users from harm. • reputational risk from staff failing to adhere to safeguarding arrangements.

As of June 2023, 95 and 155 people had been trained in level three adult and children safeguarding respectively. Whilst we recognise that the immediate risk may not be as high as that related to the more important Level One and Level Two training, there is a clear need to monitor the delivery profile.			
Recommendations			**Priority**
2.1	The Health Board should ensure that the Training Delivery Plan prioritises key staff and ensures remaining delivery milestones are monitored and steps taken to ensure ongoing, timely delivery.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	The Health Board will ensure that a clear mandate is in place on ESR, highlighting the staff required to undertake each level of training, appropriate to their role. Divisional representation at Safeguarding Committee will be required to provide assurance at each committee of their compliance, offering mitigation and a recovery plan where non-compliant.	31/12/2023	Head of Safeguarding

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Archwilio Cymru
Audit Wales

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

Date issued: September 2023

Document reference: 3503A2023

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

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

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Contents

About this document

1 This document provides the Audit, Risk and Assurance Committee with an update on 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	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 committee at July 2023 Audit. Risk and Assurance Committee
Charitable Funds:	Rob Holcombe – Director of	• This work involves undertaking risk assessment procedures to identify risks	Not yet started	To be confirmed

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
• Planning • Audit of Charitable Fund Financial Statements	Finance and Procurement	of material misstatement within the Charitable Fund's financial statements. The subsequent design and performance of our audit approach will be responsive to each assessed risk. • 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.		

Performance audit update

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

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment 2023 – Core	Nicola Prygodzics – Chief Executive Officer	Our core structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2023 core Structured Assessment work will review: • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning, management, and performance arrangements.	In progress	November 2023
		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	Planning	To be confirmed

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		on financial savings / cost improvement plans. The focus of this work is currently being developed and further details will be shared in due course.		
Follow-Up of Primary Care Services	Leanne Watkins – Director of Operations	Follow-up of recommendations made in our Primary Care services review	Reporting	November 2023
All-Wales thematic on workforce planning arrangements	Sarah Simmonds – Executive Director of Workforce and Organisational Development	This work will examine the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs. The work will be tailored to align to the responsibilities of individual NHS bodies in respect of workforce planning.	Fieldwork	November 2023

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Unscheduled Care Arrangements	Leanne Watkins – Director of Operations	This work has been carried forward from the 2020 Audit Plan, after having initially been postponed due to the pandemic. Our phase one work has examined discharge planning arrangements and patient flow. We will assess the Health Board's progress against the 2017 audit recommendations we made on discharge planning. We are also producing a report for the Health Board and its partners on the Regional Partnership Board that describes progress being made in developing whole system solutions to delayed discharges.	Reporting	To be confirmed
Quality Governance Review Follow up	Jennifer Winslade – Executive Director of Nursing James Calvert – Medical Director Peter Carr – Executive Director of	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	Planning	To be confirmed

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
	Therapies and Health Sciences	arrangements in providing assurance over its compliance.		

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
Orthopaedic Services in Wales – Tackling the Waiting List Backlog	March 2023
Digital Inclusion in Wales and Key questions for public bodies	March 2023

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.

Exhibit 4 – Audit Wales corporate documents

Title	Publication Date
Forward work programme | Audit Wales	May 2023

There are no relevant Audit Wales consultations currently underway.

Audit Wales

1 Capital Quarter, Tyndall Street,

Cardiff CF10 4BZ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

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