Audit, Risk and Assurance Committee

Tue 21 May 2024, 09:30 - 12:00

Agenda

09:30 - 09:35
5 min

1. Preliminary Matters

Oral *Chair*

1 v4ARA Committee Agenda 21_05_2024.pdf (3 pages)

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 16th April 2024

Attached *Chair*

1.4 v3 16_04_2024 Draft Audit Risk and Assurance Minutes LW - Chair Approved.pdf (9 pages)

1.5. Committee Action Log

Attached *Chair*

1.5 16_04_2024 Audit Risk Assurance Committee Action Log.pdf (3 pages)

09:35 - 10:05
30 min

2. Items for Approval/Ratification/Decision

2.1. To formally approve the recommendations contained in the reports listed below from the Committee meeting on 16th April 2024

Attached *Chair*

- Internal Audit Workplan 2024/25
- Audit, Risk and Assurance Committee Workplan 2024/25
- Three Financial Control Procedures (*Accounts Receivable, Counter Fraud Communication Strategy and Contract Management)*
- Q4 Audit Recommendation tracking closing position

2.1.1 ABUHB_2024-25_DRAFT Internal Audit Plan v1.3.pdf (30 pages)
2.1.2 Cover Paper Audit Risk and Assurance Committee Work Plan 2024_25.pdf (4 pages)
2.1.2a Appendix 1_DRAFT ARA_Committee Work Programme 2024-25 v2.pdf (6 pages)
2.1.3 Governance Report 16.04.2024.pdf (10 pages)
2.1.3a Appendix 1 ABUHB_Finance_0239 Accounts Receivable Final.pdf (27 pages)
2.1.3b Appendix 2 ABUHB_Finance_0581 Counter Fraud Communication Strategy Final.pdf (11 pages)
2.1.3c Appendix 3 ABUHB_Finance_0996 Contract Management Final.pdf (7 pages)
2.1.4 Internal_External Audit Recommendations Q4 23_ 24 Cover Report ARAC.pdf (7 pages)

2.2. To Receive the Counter Fraud 2023/24 Annual Report and Approve the Counter Fraud

Annual Work Plan 2024/25

Attached *Head of Counter Fraud*

- 2.2 ARAC Counter Fraud Annual Report 23-24, Work Plan 24-25.pdf (3 pages)
- 2.2a Counter Fraud Annual Report 2023-24.pdf (20 pages)
- 2.2b ABUHB Counter Fraud Work Plan 2024-25.pdf (11 pages)

2.3. To Receive the Clinical Audit Annual Report 2023/24 and Approve the Clinical Audit Plan 2024/25

Attached *Assistant Director for Quality and Patient Safety*

- 2.3 SBAR Final Clinical Audit Activity Report and Plan April 2024.pdf (6 pages)
- 2.3a Annual report Clinical Audit Activity 2023.24 Final.pdf (123 pages)
- 2.3b Annual Clinical Audit Plan 2024.25 Final.pdf (20 pages)

10:05 - 11:55
110 min

3. Items for Discussion

3.1. To Receive the Standards of Behaviour Policy

Attached *Director of Corporate Governance*

- 3.1 Standards of Behaviour Framework cover report.pdf (5 pages)
- 3.1a Draft Standards of Behaviour Policy RD Comments.pdf (41 pages)

3.2. Review of the Health Boards Annual Report (Overview & Performance section) Part 1

Attached *Director of Strategy, Planning and Partnerships*

- 3.2 Cover Report Annual Report ARAC.pdf (5 pages)
- 3.2a Performance Report 2024 v2 bc.pdf (36 pages)

3.3. Review Draft/Final Accountability Report, Including Annual Governance Statement (Part 2)

Attached *Director of Corporate Governance*

- 3.3 Accountability Report 23.24 v1 RD Reviewed.pdf (101 pages)

3.4. Review Draft/Final Accounts and Financial Statements (Part 3)

Attached *Director of Finance and Procurement*

- **To include losses and special payments**

- 3.4 2023-24 Draft accounts report-vfinal.pdf (19 pages)
- 3.4a Appendix 1 - Losses Special Payments - Five Year Payments.pdf (1 pages)
- 3.4b1 ABUHB 2023-24 Draft Annual Accounts.pdf (1 pages)
- 3.4b2 ABUHB 2023-24 Draft Annual Accounts.pdf (1 pages)
- 3.4b3 ABUHB 2023-24 Draft Annual Accounts.pdf (1 pages)
- 3.4b4 ABUHB 2023-24 Draft Annual Accounts.pdf (1 pages)
- 3.4b5 ABUHB 2023-24 Draft Annual Accounts.pdf (1 pages)
- 3.4b6 ABUHB 2023-24 Draft Annual Accounts.pdf (1 pages)
- 3.4b7 ABUHB 2023-24 Draft Annual Accounts.pdf (1 pages)
- 3.4b8 ABUHB 2023-24 Draft Annual Accounts.pdf (1 pages)
- 3.4b9 ABUHB 2023-24 Draft Annual Accounts.pdf (1 pages)
- 3.4b10 ABUHB 2023-24 Draft Annual Accounts.pdf (1 pages)
- 3.4b11 ABUHB 2023-24 Draft Annual Accounts.pdf (1 pages)
- 3.4b12 ABUHB 2023-24 Draft Annual Accounts.pdf (1 pages)
- 3.4b13 ABUHB 2023-24 Draft Annual Accounts.pdf (1 pages)
- 3.4b14 ABUHB 2023-24 Draft Annual Accounts.pdf (1 pages)
- 3.4b15 ABUHB 2023-24 Draft Annual Accounts.pdf (2 pages)
- 3.4b16 ABUHB 2023-24 Draft Annual Accounts.pdf (1 pages)

3.4b17 ABUHB 2023-24 Draft Annual Accounts.pdf (1 pages)
3.4b18 ABUHB 2023-24 Draft Annual Accounts.pdf (1 pages)
3.4b19 ABUHB 2023-24 Draft Annual Accounts.pdf (1 pages)
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3.4b75 ABUHB 2023-24 Draft Annual Accounts.pdf (1 pages)
3.4b76 ABUHB 2023-24 Draft Annual Accounts.pdf (1 pages)

3.5. To Review Audit Enquires to those charged with Governance and Management

Attached *Director of Finance and Procurement*

- 3.5 Audit Enquiries letter cover.pdf (3 pages)
- 3.5a ABUHB Audit Enquiries Management Letter 23-24 draft ARAC.pdf (27 pages)

3.6. To Receive the Internal Audit Progress Report – To include Head of Internal Audit Opinion and Annual Report 2023/24

Attached *Head of Internal Audit*

- 3.6 ABUHB May 2024 Audit Committee Progress Report.pdf (7 pages)
- 3.6a ABUHB DRAFT Opinion Annual Report 23-24 for Client v1.1.pdf (34 pages)

3.7. To Receive Internal Audit Reports

3.7.1. Bevan Health & Wellbeing Centre – Limited Assurance

Attached *Head of Internal Audit*

- 3.7.1 ABU Bevan HWBC Final Audit Report.pdf (28 pages)

3.7.2. Medical Equipment and Devices (Ultrasound) - Reasonable Assurance

Attached *Head of Internal Audit*

- 3.7.2 ABUHB 2324-4b ME&D (US) Final Internal Audit Report client issue.pdf (13 pages)

3.7.3. Maternity Services (Action Plan) – Substantial Assurance

Attached *Head of Internal Audit*

- 3.7.3 ABUHB 2324-21 Final Maternity Action Plan Report.pdf (8 pages)

3.7.4. Early Supported Discharge (Stroke) – Substantial Assurance

Attached *Head of Internal Audit*

- 3.7.4 AB-23.7.4 324-17 ESD Stroke Final Internal Audit Report for Client.pdf (9 pages)

3.8. To Receive the External Audit Work Plan 2024/25

Attached *Audit Wales*

- 3.8 ABUHB 2023-24 NHS Audit Plan FINAL.pdf (20 pages)

3.9. To Receive External Audit Progress Report 2024/25

Attached *Audit Wales*

- 3.9 Audit, Risk and Assurance Committee Update May 2024.pdf (10 pages)

11:55 - 12:00
5 min

4. Items for Information

4.1. To Receive Primary Care Follow-up Report - following amendments to recommendation status

Attached *Director of Corporate Governance*

- 4.1 3564A2023_abuhb_primary_care_follow-up_final.pdf (25 pages)

12:00 - 12:00
0 min

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

Oral *Chair*

- Tuesday 9th July 2024 (Final Accounts)

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

AUDIT, RISK & ASSURANCE COMMITTEE AGENDA	
Date and Time	**Tuesday 21st May at 09:30**
Venue	**Microsoft Teams**

Item	Title	Format	Presenter
1	**PRELIMINARY MATTERS**		
1.1	Welcome and Introductions	Oral	Chair
1.2	Apologies for Absence	Oral	Chair
1.3	Declarations of Interest	Oral	Chair
1.4	Draft Minutes of the last meeting held on 16th April 2024	Attached	Chair
1.5	Committee Action Log	Attached	Chair
2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
2.1	To formally approve the recommendations contained in the reports listed below from the Committee meeting on 16 April 2024: - Internal Audit Workplan 2024/25 - Audit, Risk and Assurance Committee Workplan 2024/25 - Three Financial Control Procedures (*Accounts Receivable, Counter Fraud Communication Strategy and Contract Management)* - Q4 Audit Recommendation tracking closing position	Attached	Chair
2.2	To Receive the Counter Fraud 2023/24 Annual Report and Approve the Counter Fraud Annual Work Plan 2024/25	Attached	Head of Counter Fraud
2.3	To Receive the Clinical Audit Annual Report 2023/24 and Approve the Clinical Audit Plan 2024/25	Attached	Assistant Director for Quality and Patient Safety
3	**ITEMS FOR DISCUSSION**		



3.1	To Receive the Standards of Behaviour Policy	Attached	Director of Corporate Governance
3.2	Review of the Health Boards Annual Report (Overview & Performance section) Part 1	Attached	Director of Strategy, Planning and Partnerships
3.3	Review Draft/Final Accountability Report, Including Annual Governance Statement (Part 2)	Attached	Director of Corporate Governance
3.4	Review Draft/Final Accounts and Financial Statements (Part 3) – To include losses and special payments	Attached	Director of Finance and Procurement
3.5	To Review Audit Enquires to those charged with Governance and Management	Attached	
3.6	To Receive the Internal Audit Progress Report – To include Head of Internal Audit Opinion and Annual Report 2023/24	Attached	Head of Internal Audit
3.7	To Receive Internal Audit Reports	Attached	
3.7.1	- Bevan Health & Wellbeing Centre – Limited Assurance	Attached	
3.7.2	- Medical Equipment and Devices (Ultrasound) - Reasonable Assurance	Attached	
3.7.3	- Maternity Services (Action Plan) – Substantial Assurance	Attached	
3.7.4	- Early Supported Discharge (Stroke) – Substantial Assurance	Attached	
3.8	To Receive the External Audit Work Plan 2024/25	Attached	Audit Wales
3.9	To Receive External Audit Progress Report 2024/25	Attached	
4	**ITEMS FOR INFORMATION**		
4.1	To Receive Primary Care Follow-up Report - following amendments to recommendation status	Attached	Director of Corporate Governance
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 9th July 2024 (Final Accounts)		

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

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

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

DATE OF MEETING	Tuesday 16th April 2024
VENUE	Microsoft Teams

PRESENT	Iwan Jones - Independent Member, Committee Chair Dafydd Vaughan - Independent Member *(co-opted for quorum)*
IN ATTENDANCE	Rani Dash- Director of Corporate Governance Lucy Windsor – Head of Corporate Risk and Assurance Rob Holcombe - Director of Finance and Procurement Nicola Prydgodzicz – Chief Executive, ABUHB Stephen Chaney – Deputy Head of Internal Audit Sara Utley – Audit Wales Left 13:46 Mark Ross – Assistant Finance Director Andrew Doughton – Audit Wales Julie Rees – Audit Wales – Left 13:46 Leanne Watkins – Chief Operating Officer *(left at 13:50)* Lloyd Hambridge – Head of Primary Care and Community *(left at 13:50)* Danielle Jackson – Secretariat
Apologies	Richard Clark– Independent Member, Committee Vice Chair

ARAC 1604/1	**Preliminary Matters**
ARAC 1604/1.1	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
ARAC 1604/1.2	**Apologies for Absence** Apologies were noted. Rani Dash (RD), Director of Corporate Governance, informed the committee that due to apologies, the Committee meeting was not quorate in terms of the Committee Terms of Reference; however, a decision was made to proceed on the basis of two independent members being satisfactory in accordance with the Audit Committee Handbook Guidance, which would be documented and reported in the Annual Governance Statement (AGS).
ARAC 1604/1.3	**Declarations of Interest** There were no declarations of interest raised to record.

ARAC 1604/1.4	**Minutes of the previous meeting** The minutes of the meeting held on the 8th February 2024 were agreed as a true and accurate record.
ARAC 1604/1.5	**Committee Action Log** The Committee reviewed the action log, noting actions completed, actions in progress, and actions that were not yet due. The Committee agreed to complete the following action; **ARAC1807/2.1** Clinical Audit Update - The Patient Quality, Safety and Outcomes Committee would be responsible for monitoring Clinical Audit outcomes. **ARAC 0802/3.9** On the basis that meetings have taken place, and the Corporate Risk Register would be presented to the Board in July.
ARAC 1604/2	**Items for Discussion**
ARAC 1604/2.1	**To Receive External Audit Progress Report** Sara Utley (SU), Audit Wales, provided the Committee with a summary of the External Audit Progress Report, including an update on Stakeholder Survey. It was reported that there were five current and planned audits including; - Structured Assessment deep dive. - Follow-up of Primary Care Services - Unscheduled Care Arrangements - Follow-up Quality Governance Review - Tackling NHS waiting lists The Committee was informed that following the Stakeholder Perception report three main priorities had been identified for the strategic dynamic and high-quality audit programme, as well as a targeted and impactful approach to communications and influencing, which will be incorporated into the External Audit Workplan for 2024/25. It was noted that the External Audit Annual Plan 2024/25 had been circulated to Board members and would be presented formally at the next Committee meeting. The Committee **NOTED** the Report

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ARAC 1604/2.2	**To Review the Primary Care Follow-up Report** Sara Utley (SU), Audit Wales, provided the Committee with an update of the revised Primary Care Follow-up Report following amendments made to the management response by the Health Board. Iwan Jones (IJ), Chair, expressed concerns about the recommendations in the report marked as 'completed' and 'will continue ongoing', and requested that actions either be noted as completed or deadlines agreed with management in order to track progress. SU confirmed that the recommendation status/agreed completion dates would be reviewed, updated and presented back to the committee at the next scheduled meeting. **ACTION: Secretariat** The Committee **NOTED** the Report
ARAC 1604/2.3	**To Receive Internal Audit Progress Report** Stephen Chaney (SC), Head of Internal Audit, provided a summary of the Internal Audit Progress Report to the Committee. It was reported that from the 2023/24 Internal Audit Plan 13 audits have been reported in final, 6 have been produced in draft, 7 remain in progress and 1 remains at the planning stage. The Committee **NOTED** the Report
ARAC 1604/2.4	**To Receive Internal Audit Reports** Stephen Chaney (SC) - Head of Internal Audit, provided the Committee with an overview of the following five reports. **Unified Breast Unit – Substantial Assurance** It was reported that the audit sought to review the management arrangements in place to progress the Ysbyty Ystrad Fawr Unified Breast Cancer Unit. The Committee was informed that overall, the audit was positive, noting that the project was forecast to generate a small surplus of £200,000. A small number of recommendations were raised to improve further including; Record keeping and Completeness of reports. **Asset Management – Reasonable Assurance** The Committee was informed that the review focused on the management of assets and associated record keeping with a particular focus on the roll-out of radio frequency (RFID) tagging process.

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It was noted that positive progress to introduce the RFID process at 67% with an anticipated completion date of March 2025.

There were a number of areas of improvement highlighted including; Disposal of assets, record management of new assets and the physical verification process. It was noted that the introduction of the RFID process would be expected to resolve the majority issues surrounding these.

Iwan Jones (IJ), Chair, raised concerns surrounding the 25% error rate found within the physical verification process. SC, confirmed that it was anticipated that issues raised were expected to be resolved following introduction of the RFID as well as other recommendations made.

Risk Management & Assurance – Reasonable Assurance
It was reported that the review focused on risk management within the digital directorate. Overall, the processes within the digital directorate for managing risk were robust but there were a number of processes completed manually which could be improved by a more automated approach.

Lucy Windsor (LW), Head of Corporate Risk and Assurance, informed the Committee that a meeting had been scheduled with the digital directorate to transfer all risks from manual spreadsheets to the Datix Risk Module.

Dafydd Vaughn (DV), Independent Member, asked whether the traditional corporate risk approach was suited to managing digital technology risks due to the fast-paced environment SC confirmed that there was a very proactive approach to managing risk within the digital directorate and that programme risks were managed slightly differently but were well managed.

Rani Dash (RD), Director of Corporate Governance advised the Committee that the Risk Management Framework made a clear distinction between managing programme risks and business risks.

Long-Term Sickness Absence Management – Reasonable Assurance
It was reported that the review took place over a sample of areas to determine compliance with the NHS Wales Managing Absence at Work Policy. Overall, a good level of compliance with the policy was found, particularly within the facilities department.

Follow-up of High Priority Recommendations - **Advisory**

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	The Committee was informed that the review in undertaken annually to ensure all high recommendations are appropriately managed. It was reported that positive arrangements were found to be in place, overall, a positive report. The Committee **NOTED** the audit reports for assurance.
ARAC 1604/2.5	**To Receive an Early Indication on the Head of Internal Audits Final Opinion Report** Stephen Chaney (SC), Head of Internal Audit, provided the Committee with an update on the Internal Audit Final Opinion Report, noting that the number of limited assurance reports had improved, and Internal Audit was hopeful that this trend would continue, as it was seeing increased engagement and improvement as a result of previous audit recommendations, as well as greater visibility of risk management practices in place. The Committee **NOTED** the update.
ARAC 1604/2.6	**To Receive and Endorse the Internal Audit Annual Workplan for 2024/25** Stephen Chaney (SC), Head of Internal Audit, provided the Committee with an overview of the proposed 2024/25 Internal Audit Workplan. The Committee **ENDORSED** the 2024/25 Workplan in principle but agreed it would be presented back to the Committee in May for formal approval. **ACTION: Secretariat**
ARAC 1604/2.7	**To Receive the Committee Risk and Assurance Report** Lucy Windsor (LW), Head of Risk and Assurance, presented the Committee with an overview of the Risk and Assurance Report. It was reported that two risks have been de-escalated, there had been a reduction in the risk score and exposure of a further two risks and one new strategic risk had been identified, which was currently being worked through; a full risk assessment would be presented to the Board in May 2024. Seven risks were being managed outside of the agreed appetite for the risk domain, meetings with risk owners were being scheduled to deep dive the risk and put in place action plans to reduce the risk to a tolerable level. The Committee was informed that the Corporate Risk Register is in the process of being developed and meetings with executive directors to discuss potential operational risks had taken place. It

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	was anticipated that the work would be completed by June and presented to the Board in July. The Committee **NOTED** the Report for Assurance.
ARAC 1604/3	**ITEMS FOR APPROVAL / RATIFICATION / DECISION**
ARAC 1604/3.1	**To Approve the Audit, Risk and Assurance Committee Work Plan 2024/25.** Rani Dash (RD), Director of Corporate Governance, presented the Committee workplan for 2024/25, noting that the workplan had been produced in line with the Committee's Terms of Reference (ToR) and delegated responsibilities. The Committee was informed that it would retain responsibility for receiving and approving the Clinical Audit plan, as per the NHS Wales Audit Committee Handbook, however, the outcomes of clinical audit activity would be monitored by the Patient, Quality, Safety and Outcomes Committee. The Committee **AGREED** the 2024/25 Work Plan in principle but requested it come back to the next meeting for formal approval. **ACTION: Secretariat**
ARAC 1604/3.2	**To Approve the Audit, Risk and Assurance Annual Report 2023/24.** Rani Dash (RD), Director of Corporate Governance, presented the 2023/24 Committee Annual Report and requested endorsement prior to submission to the Board in May. The Committee was encouraged by the report's content and the work undertaken throughout the year, and it thanked everyone for their efforts in submitting the required reports, allowing the Committee to receive the necessary assurance on behalf of the Board. The Committee **ENDORSED** the 2023/24 Annual Report and agreed that the report would come back to the next meeting for formal approval. **ACTION: Secretariat**
ARAC 1604/3.3	**Review Internal and External Audit Recommendations Tracking** Lucy Windsor (LW), Head of Corporate Risk and Assurance, provided the Committee with a summary of the Internal and External Audit Recommendation Tracker - January 2024 to March 2024.

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	It was reported that following the last reporting period, up to 31 December 2023 a further 104 recommendations had triggered as overdue resulting in 116 recommendations requiring an update. The Committee was asked to approve the 61 recommendations that had proposed revised timescales and the 50 completed. which left a residual position of 5 medium priority overdue recommendations, three of which are from audit year 2022/23 and two from audit year 2023/24. Iwan Jones (IJ), Chair advised that the Committee would benefit from understanding how many times recommendations had requested a revised timescale. LW committed to including that information in the next report to the Committee. **Action: Head of Corporate Risk & Assurance** Rani Dash (RD), Director of Corporate Governance, suggested that realistic timeframes be included in initial reports to reduce the need to extend revised timeframes as frequently. Stephen Chaney (SC), Head of Internal Audit, informed the Committee that upon finalisation of reports, it was suggested that contingency time be factored into completion dates, and that this would be reinforced. The Committee **NOTED** the report and **APPROVED IN PRINCIPLE** the 61 revised timescale requests and 30 completed recommendations. A summary of Q4 closing position would be included in the next report for formal approval. **ACTION: Head of Corporate Risk and Assurance.**
ARAC 1604/3.4	**To Approve the Report on the use of Single Tender Action** Mark Ross (MR), Assistant Finance Director, provided the Committee with a summary on Single Tender Action Waivers – 20 January 2024 to 22 March 2024. The Single Tender Action (STA) schedule contained a summary of the ten STA requests that had been submitted and approved to a total value of £1,443,455.97 excluding VAT – 20 January 2024 – 22 March 2024 • Mobile Decontamination Unit Extension • Security • Bespoke Cot Bed/Safe Space for Child LP • Bespoke Cot Bed/Safe Space for Child ES • Nurses Accommodation • Domestic Violence and abuse (DVA) training, support and referral programme – NCN Primary/Community. • Fibroscan Mini Machine – YYF Outpatients

	• Gritting North Gwent • Educational update for GP Practices CPD • International Nurses Accommodation Iwan jones (IJ), Chair queried the increase in the number of STAs requested in comparison to the typical small number usually received. MR advised that there had been no concerns in the number of STAs requested and no trends were observed. Dafydd Vaughn (DV), Independent Member raised concerns surrounding the STA requests for security and North Gwent Gritting. Rob Holcombe (RH), Director of Finance and Procurement reassured the Committee that market testing and cost comparisons were conducted; however, a decision was made to not formally tender. DV asked if there was any ongoing work being done to ensure that suitable accommodation was available for nurses and international nurses in the future, and if the Committee could expect to see regular STAs. RH confirmed that Workforce was working to find a more suitable solution for nurse accommodation; however, he noted that STA requests for accommodation may be used again due to the difficulty of obtaining appropriate accommodation due to location. DV requested that the Director of Workforce and Organisational Development provide the People and Culture Committee with a detailed update on the efforts to secure long-term accommodation for Nurses/International Nurses. **ACTION: Secretariat and Director of Workforce and OD** The Committee received a summary of the processes followed when completing STA requests, specifically in relation to the Community Transport Association as requested at the previous Committee meeting held 8th February 2024. The Committee **NOTED** the report.
ARAC 1604/3.5	**Ratification of Financial Governance, Reporting and Control Procedures.** Mark Ross (MR), Assistant Finance Director, presented the financial governance report and requested approval of the three Financial Control Procedures listed below. • Accounts Receivable • Counter Fraud Communication Strategy • Contract Management

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	Iwan Jones (IJ), Chair, inquired about how credit was extended and whether a credit risk assessment/check was completed prior to advancing funds before receiving goods/services. Rob Holcombe (RH), Director of Finance and Procurement, informed the Committee that it was general policy that payments were not made in advance, and thus credit was not provided. It was reported that the NHS Public sector payment remained in a good position, at just below the 95% target; the non-NHS payment remained in a positive position, above 95%. The Committee **NOTED** the contents of the report and **APPROVED IN PRINCIPLE** the three financial control procedures but requested these be presented back to the next Committee for formal approval. **ACTION: SECRETERIAT**
ARAC 0802/4	**Items for Information**
ARAC 2811/5	**Other Matters**
ARAC 2811/5.1	**Items to be Brought to the Attention of the Board and Other Committees** The People and Culture Committee to receive a detailed update on the efforts to secure long-term accommodation for Nurses/International Nurses.
ARAC 2811/5.2	**Any Other Urgent Business** No items for any other business.
ARAC 2811/5.3	**Date of the next meeting;** • Tuesday 21st May 2024 (Draft Accounts)

DRAFT

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

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
November 2023	**ARAC 2811/3.1** Losses and Payments Report	Circulate a briefing note to Committee Members detailing the Losses and Special Payments made by the Health Board.	Director of Finance and Procurement	21 May 2024	**Completed.** Included within item 4.3 Review Draft/Final Accounts and Financial Statements (Part 3) presented at meeting held 21_05_2024
November 2023	**ARAC 2811/3.4** Job Planning Arrangements	Following full implementation of the job planning process an update report is to be received at a future meeting to provide assurance that all audit recommendations have been implemented.	Medical Director Secretariat	Schedule for Q2 2024/25.	**Not Yet Due.**
February 2024	**ARAC 0802/3.1** To receive Counter Fraud Report	Explore data available via ESR in relation to staff mandatory training.	Head of Counter Fraud	21 April 2024	**Completed.** Included within Annual Fraud report presented at meeting held 21_05_2024



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

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
April 2024	**ARAC 1604/1.2**	All items that require approval to be brought back to the next committee meeting for formal approval due to lack of quoracy.	Secretariat	21 May 2024	**Completed.** On the agenda. • Internal Audit Workplan 2024/25 • Audit, Risk and Assurance Committee Workplan 2024/25 • Three Financial Control Procedures (*Accounts Receivable, Counter Fraud Communication Strategy and Contract Management)* • Primary Care Follow up report (Updated status)
April 2024	**ARAC 1604/2.2 Follow-up Primary Care Report**	Recommendations be reviewed and either be noted as "completed" or numerical deadlines agreed and brought back to the committee.	Secretariat and Audit Wales	21 May 2024	**Completed.** On 21st May 2024 Agenda



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

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
April 2024	**ARAC 1604/3.3** Review Internal and External Audit Recommendations Tracker	Explore ways to include data of requested timescale extension requests within future reports.	Head of Risk and Assurance	July 2024	**Not Yet Due**
April 2024	**ARAC 1604/3.4** Report on the use of Single Tender Action	The People and Culture Committee to receive a detailed update on the efforts to secure long-term accommodation for Nurses/International Nurses.	Secretariat	April 2024	**Completed.** **Transferred to P&C Committee.**

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.



Annual Internal Audit Plan
Internal Audit Charter

mai 2024

Aneurin Bevan University Health Board

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Disclaimer notice - please note

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

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

1. Introduction

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

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

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

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

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

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

1.1 National Assurance Audits

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

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

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

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

2.2 Risk based internal audit planning approach

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

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

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

concerns from our discussions with management, and emerging risks.

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

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

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

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

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

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

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

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

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

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

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

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

2.3 Link to the Health Board's systems of assurance

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

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

2.4 Audit planning meetings

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

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

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

3. Audit risk assessment

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

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

4. Planned internal audit coverage

4.1 Internal Audit Plan 2024/25

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

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

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

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

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

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

4.2 Keeping the plan under review

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

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

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

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

5. Resource needs assessment

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

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

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

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

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

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

6. Action required

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

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

Stephen Chaney
Head of Internal Audit
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2024/2025

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

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

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

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

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

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

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

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

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

Appendix B: Key performance indicators (KPI)

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

Appendix C: Internal Audit Charter

1 Introduction

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

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

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

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

2 Purpose and responsibility

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

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

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

arrangements comprise:

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

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

3 Independence and Objectivity

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

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

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

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

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

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

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

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

4 Authority and Accountability

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

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

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

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

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

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

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

5 Relationships

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

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

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

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

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

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

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

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

6 Standards, Ethics, and Performance

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

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

7 Scope

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

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

concern identified in the corporate risk register;

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

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

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

8 Approach

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

Figure 1: Audit planning hierarchy

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

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

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

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

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

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

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

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

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

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

9 Reporting

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

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

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

9.2 The process for audit reporting is summarised below:

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

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

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

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

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

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

10 Access and Confidentiality

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

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

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

11 Irregularities, Fraud & Corruption

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

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

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

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

12 Quality Assurance

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

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

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

13 Resolving Concerns

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

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

14 Review of the Internal Audit Charter

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

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

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

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

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

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

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Audit Risk and Assurance Committee is asked to consider the draft Committee work plan appended to this report for approval. The work plan has been developed with due regard to recommendations from the Committee Mid-Year Self-Assessment and the guidance set out in NHS Wales' Audit Committee Handbook (June 2012) to enable the Audit, Risk and Assurance Committee to: -

- Fulfil its Terms of Reference (to be agreed by the Board May 2024);
- seek assurance and provide scrutiny on behalf of the Board, in relation to the delivery of the key elements of the Health Boards internal and external audit, counter fraud and PPV arrangements (second and third lines of defence);
- seek assurance that governance, risk, and assurance arrangements are in place and working well;
- seek assurance in relation to the preparation and audit of the Annual Accounts; and
- ensure compliance with key statutory, national, and best practice audit and assurance requirements and reporting arrangements.

Cefndir / Background

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

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

Asesiad / Assessment

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

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

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

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

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

Assurance will be provided through the following mechanisms: -

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

- The Internal and External Recommendations Tracker.

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

Argymhelliad / Recommendation

The Committee is requested to:

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

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

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

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

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

ANNUAL PROGRAMME OF BUSINESS 2024/25

AUDIT, RISK & ASSURANCE COMMITTEE

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

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

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

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

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

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

DRAFT

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

DRAFT

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

DRAFT

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

DRAFT

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

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

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

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

DRAFT

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	16 April 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Financial governance, reporting & control.**
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	**Robert Holcombe, Director of Finance, Procurement and Value Based HealthCare**
SWYDDOG ADRODD: **REPORTING OFFICER:**	**Mark Ross, Assistant Finance Director**

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

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

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

The Audit, Risk and Assurance Committee is requested to:

- Note the contents of this report.



- Approve the updated financial control policy and procedures.

    - Accounts Receivable (Appendix 1)
    - Counter Fraud Communication Strategy (Appendix 2)
    - Contract Management (Appendix 3)

Cefndir / Background

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

The FCPs presented will be considered by the Executive Committee at their meeting on the 4th April and are presented to the Audit, Risk and Assurance Committee for approval subject to Executive Committee approval at that meeting.

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

Asesiad / Assessment

1.Financial Control Procedures (FCP)

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

- Accounts Receivable (Appendix 1)
- Counter Fraud Communication Strategy (Appendix 2)
- Contract Management (Appendix 3)

A summary of the main changes to each of the Financial Control policy/procedure is set out below. The full revised FCPs are included in Appendix 1 - 3.

1. Accounts Receivable

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

The procedure sets out the requirements to ensure there are adequate controls in place to identify all sources of income, due to the Health Board.

Once income is identified, a control framework is to be followed, to ensure all income due is invoiced, collected, and accounted for correctly.

The document has been circulated for comment as follows:

- Assistant Head of Financial Services
- Head of Financial Services and Accounting
- Assistant Director of Workforce (Workforce & Organisational Development)
- NWSSP – Payroll Services



- NWSSP - Audit and Assurance Services

Main changes to the document

Paragraph	Summary of change
All	Organisational change - Director of Finance changed to Director of Finance, Procurement and Value
All	Intranet links added for internal documents
6.8, 7.1, 7.1.15	Process change – reference to the NWSSP – Payroll Services introduction of an Overpayments Platform in order to monitor, communicate and report overpayments of salary to employees
7	Procedure update – reference added in relation to the All-Wales NWSSP Overpayments Procedure which is currently being developed
7.4.2.2	Guidance update – Welsh Government arbitration guidance updated from 'Welsh Health Circular 2019_014' to 'Welsh Health Circular 2022_013'
7.4.2.6	Process update – reference to the requirement to report Overseas Visitors debt status, on a monthly basis, to the Department of Health & Social Care

2. Counter Fraud Communication Strategy

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

The Counter Fraud Communication Strategy has been established to promote and raise awareness of the NHS counter fraud initiative.

The Local Counter Fraud Specialist (LCFS) is committed to ensuring that effective communication is undertaken to deter fraud and prevent the organisation from falling victim to fraudulent practices.

The document has been circulated for comment as follows:

- Head of Communications
- Director of Corporate Governance
- NWSSP - Audit and Assurance Services

Main changes to the document

Paragraph	Summary of change
All	Organisational change - Director of Finance changed to Director of Finance, Procurement and Value.
All	Organisational change – Board Secretary changed to Assistant Director of Communications and Engagement



All	Organisational Change – Audit Committee changed to Audit, Risk and Assurance Committee
All	Intranet links added for internal documents/external websites
5.1	Contact Points – Local Counter Fraud phone number and email updated
5.2	Contact Points – NHS Fraud and Corruption Reporting phone number and online link updated
5.3	Contact Points – NHS Counter Fraud Authority Media Team email updated

3. Contract Management

Owner: Director of Finance, Procurement and Value
Review Date: New procedure.

The procedure outlines the roles and responsibilities for managing contracts, with the use of standard templates, throughout the life cycle of the contract to ensure proactive contract management takes place.

It is recommended that all contracts with a total value greater than £100,000 are included under the procedure, as well as any lower value strategic/business critical contracts that would benefit from proactive management.

The procedure has been created from an Internal Audit recommendation to implement a standard contract management approach and understanding across all divisions.

A training and awareness programme, headed by Procurement, will run alongside this document.

The document has been circulated for comment as follows:

- General Managers across
  - Primary Care
  - Clinical Support Services
  - Medicine
  - Scheduled Care
  - Mental Health & Learning Disabilities
  - Urgent Care
  - Digital
  - Families & Therapies
  - Estates & Facilities
- Head of Financial Services and Accounting
- Assistant Finance Director (Hospital & Corporate)
- NWSSP - Audit and Assurance Services

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

FCP	Year Due	Approved	Committee Approved	Review Date	Notes
Accounts Receivable	23/24	Due for review	Feb-21	04-Feb-24	Scheduled for Apr 24
Approval of Orders over £100K	23/24	Due for review	Feb-21	04-Feb-24	On hold until SoD Approved
Counter Fraud Communication Strategy	23/24	Due for review	Mar-21	12-Mar-24	Scheduled for Apr 24
Contract Management	New	New	New	New	Scheduled for Apr 24
Salary Sacrifice	24/25	Y	Aug-21	12-Aug-24	
Policy for Out of Area Referrals to Secondary Care	24/25	Y	Aug-21	12-Aug-24	
Overseas Visitors	24/25	Y	Feb-22	03-Feb-25	
Charitable Funds	25/26	Y	Apr-22	19-Jul-25	
Recovery of Overpayments to Employees	25/26	Y	Aug-22	02-Aug-25	
Budgetary Control Policy & Procedure	25/26	Y	Aug-22	02-Aug-25	
Losses and Special Payments	25/26	Y	Oct-22	06-Oct-25	
Stores & Stocks	25/26	Y	Oct-22	06-Oct-25	
Counter Fraud Bribery and Corruption Policy	25/26	Y	Oct-22	25-Nov-25	
Capital Assets and Charges	25/26	Y	Dec-22	01-Dec-25	
Engaging Off Payroll Workers	25/26	Y	Feb-23	02-Feb-26	
Accounts Payable	25/26	Y	Feb-23	02-Feb-26	
Patients' Property	25/26	Y	Feb-23	02-Feb-26	
Purchasing Cards	25/26	Y	Feb-23	02-Feb-26	
General Ledger	26/27	Y	Apr-23	18-Apr-26	
Policy and Governance approach for Commissioning Additional (External & Insourced) Non NHS Clinical Services	26/27	Y	Apr-23	18-Apr-26	
Procurement Policy	26/27	Y	Sep-23	12-Sep-26	
Capital Procedures and Guidance Notes	26/27	Y	Nov-23	28-Nov-26	
Patients' Travel Costs Policy	26/27	Y	Nov-23	28-Nov-26	
Cash and Bank	26/27	Y	Nov-23	28-Nov-26	
Petty Cash	26/27	Y	Feb-24	08-Feb-27	
Petty Cash - Mental Health	26/27	Y	Feb-24	08-Feb-27	

2. Annual Accounts Timetable

Key Dates for Annual Accounts 2023/24

The Health Board have now received the confirmed dates for the submission of the draft and audited 2023/24 annual accounts. These along with other key dates are shown in the table below.

It is planned to take the final accounts for approval to the scheduled Board meeting on the 11th of July.

Annual Reports 2023/24 - Key Dates	**2024**	
First draft Performance Report and Accountability Report for consideration by Exec Team	Thurs	27-Apr
Unaudited accounts and associated returns to WG	Fri	03-May noon
Draft Performance Report Overview, Accountability Report and Remuneration Report to WG	Fri	10-May
Audit, Risk and Assurance Committee meeting to Consider Draft Accounts and Draft Accountability Report	Tues	21-May
Final Accounts & Accountability Report to Audit, Risk and Assurance Committee		04-July **Exact date TBC**



Audit, Risk and Assurance Committee meeting to Consider Final Accounts, and Accountability Report	Tues	09-July
Board meeting to approve Final Accounts and Accountability Report	Thurs	11-July
Final Annual Report Deadline for Submission to WG – Annual Report and Accounts as a single unified document	Mon	15 July noon
Annual General Meeting – to receive the Annual Report and Accounts		**TBC**

3.Technical Accounting Issues

Technical updates

There have been three technical accounting updates issued by Welsh Government since the last Audit, Risk and Assurance Committee meeting.

Update note 4 covered the following area.

- Task Force on Climate related Financial Disclosure (TCFD) aligned disclosure 2023-24. The PES paper providing guidance of the preparation of Annual Reports and Accounts (ARA) for 2023-24 highlighted a new requirement re TCFD aligned disclosure. The likelihood is that the phase 1 requirements will be applied by Welsh Government in 2023-24. A formal decision for the rest of Wales has not yet been made. Health Bodies were asked to submit and issues or concerns if NHS Wales were asked to implement this in 2023/24.

Update Note 5 covered the following areas.

- Final 2023-24 Audit Submission date – confirmed as 15th July 2024
- 2023-24 losses – all requests re novel/contentious issues to be submitted to Welsh Government by 13th March 2024
- Confirmation by the 28th of March that the 2023-24 charitable accounts for our organisation do not exceed the materiality threshold of £15m re assets, liabilities, income, and expenditure.
- 2023-24 NHS Charites Accounts – Leases – confirmation required by 19th February 2024 as to whether the ABUHB Charitable accounts include any operating or finance leases that under the FreM would fall within the scope of IFRS16. Email sent to WG 15.02.2024 in response this this request.
- Transfers in – S1 & S2 forms to be submitted by 28th March.
- Agreement of Balance Exercise – Month 11 – debtors statements to be issued by Monday 4th March 2024.
- 2023-24 Year-end arrangements with Welsh Government – invoices to be raised to Welsh Government by 5th March 2024 clarifying if payment is required in March.
- Last day for Cash payments between NHS Organisations – 19th March 2024 to be received by 21st March 2024. No further payments to be made unless agreed by the receiving organisation.



- Non-Cash Requests – final date for any changes to non-cash values including IFRS16 is 15th April (TBC).
- Arbitration deadlines – clarification of the process re agreement of balances and confirmation that invoice older than 17 weeks must not be included in the agreements. Last date to submit and arbitration case is 15.04.202.
- Year-end arrangements re Notional Pensions – same arrangements re last year with information being submitted by 12th April 2024. Information from the NHSBSA Pensions Division will be issued in March 2024.
- Cash arrangements – strategic and working balances cash support will be available for draw down from 15th March 2024. Cash returns to be submitted by 27th March 2024.
- Greenbury Information – Welsh government employees on secondment to be notified to WG so that they can request the relevant information.
- Return of LHB bank interest – interest net of bank charges is payable to WG. Returns to be submitted by 8th March 2024. No payment made by ABUHB.
- Welsh Risk Pool Returns – timetable to be discussed at the next WRP sub-group meeting on the 27th of February 2024.

Update Note 6 covered the following areas.

- WG confirmed receipt date for invoices to guarantee payment by 31st March 2024 – Monday 18th March 2024.
- 2024 PFI – notification of upcoming PFI data collection – to take place in May -July 2024.
- AGM deadline for 2023024 annual accounts – 30th September 2024.
- Welsh Risk Pool Returns – various dates between 8th April 2024 – 19th April 2024

4. Public Sector Payment Policy (PSPP)

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

Category	Invoices	In Mth %	YTD %
NHS	Value Number	94.9 84.6	94.4 88.3
Non NHS	Value Number	98.3 98.2	97.1 97.3

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

There has been a slight decrease in the number & Value of NHS invoices paid within 30 days this month. NHS invoices in breach of the 30-day payment terms have been analysed for months 4-10. Divisions managers are in the process of being contacted



to make them aware of the non-compliance with a request to take the appropriate action.

5. Payments in Excess of £100K

There were no exceptional issues to report.

6. Standing Financial Instructions

There is no further update on the standing financial instructions.

Argymhelliad / Recommendation

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

- Accounts Receivable
- Counter Fraud Communication Strategy
- Contract Management

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



Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	FCP – Financial Control Procedure IFRS – International Financial Reporting Standards PSPP – Public Sector Payment Policy NWSSP – NHS Wales Shared Services Partnership LCFS – Local Counter Fraud Specialists WG – Welsh government TCFD - Task Force on Climate related Financial Disclosure PES – Public Expenditure System ARA – Annual Reports & Accounts TBC – To be confirmed
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment: • **Workforce** • **Service Activity & Performance** • **Financial**	**Is EIA Required and included with this paper?** A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following: Not Applicable Yes, outlined within the paper Yes, outlined within the paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.



	If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.

Aneurin Bevan University Health Board

Financial Control Procedure Accounts Receivable

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

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

Issue date: DRAFT
Review by date: DRAFT
Policy Number: ABUHB/Finance/0239

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1 Introduction

This policy covers the recovery of all monies due to Aneurin Bevan University Health Board and the correct accounting thereof.

2 Policy Statement

The policy sets out the requirements of the Health Board to ensure there are adequate controls in place to identify all sources of income due to the Health Board, to ensure it is promptly recovered and accurately accounted for. This Financial Control Procedure should be read in conjunction with Aneurin Bevan University Health Board's Standing Financial Instructions and the Recovery of Overpayments to Employees procedure.

3 Aims

The purpose of this document is to clearly set out the responsibilities of Health Board staff to ensure that all income due to the Health Board, which is not collected at the point of service or sale is:

- Invoiced to the appropriate debtor promptly and in accordance with agreed tariffs and other charging arrangements.
- All invoices should be processed through the Accounts Receivable department.
- Accounted for in the reporting period to which the income relates.
- Properly pursued with adequate arrangements for the collection of income due.

4 Objectives

The objective of this procedure is to clearly set out a control framework to ensure that all income due to the Health Board is identified, invoiced, collected within the Health Board's stated terms of payment (including referral to the Health Board's debt collection agency), and accounted for in the correct period.

5 Scope

This document relates to staff as follows:

- All staff and managers who raise income requests across the organisation.
- Staff within the Corporate Finance department who provide the cash and banking function for the organisation and those staff who are responsible for authorisation where appropriate.
- Staff within the Accounts Receivable function who raise invoices and chase payment thereof.
- Staff within the NWSSP payroll department with responsibility for raising income request forms relating to overpayments.

6 Roles and Responsibilities

6.1 Managers who generate income

Are responsible for:

- Initiating the raising of invoices, by the submission of a correctly completed and authorised income request form to the Accounts Receivable Department, to ensure that all income due to the Aneurin Bevan University Health Board is requested from the recipients of goods or services supplied.
- Ensuring that there is appropriate documentation available to support any agreements for goods and services provided in order to minimise payment disputes.
- Engaging in the resolution of disputes when invoices are not promptly paid.
- Directorate Managers are responsible for carrying out a periodical review to ensure that all sources of income are identified.

6.2 Central Management Accounts Team

Are responsible for:

- Completing the auto invoice upload spreadsheet with the mandatory information for each invoice.
- E-mailing the appropriately completed spreadsheet for upload to the ledger via the Auto Invoice process to the Accounts Receivable Officers. The email should state the number and value of invoices to be raised and have the auto invoice spreadsheet as an attachment.

- The Spreadsheet should show the PO number of the receiving customer, as appropriate. If no PO is available, the CMA team will endeavour to provide this in a timely manner, to assist the Accounts Receivable team to manage chasing the debt with the customer.
- The VAT treatment of each transaction will be considered and assessed prior to raising the invoice request.
- The CMA team should liaise with the Financial Services Manager – VAT to ensure the correct VAT treatment has been applied, and that any contracts relating to the income request are kept by the Financial Services Manager – VAT, in anticipation of any request made by HMRC to review the income transaction.

6.3 Accounts Receivable Manager

Is responsible for:

- Month-End closedown of the Accounts Receivable module in Oracle and production of all month end reconciliations and reports.
- Checking credit note requests to supporting information and applying the credit note to the invoice in the ledger.
- Referring debts to the Health Board's debt collection agency where appropriate.
- Reviewing the list of outstanding debts on a monthly basis with the Treasury Manager and Assistant Head of Financial Services and considering court action where appropriate and recommended by the Health Board's debt collection agency.
- Applying the NHS Arbitration process to NHS Wales debts.
- Preparing a schedule of debts for write off to be submitted for approval, see section 7.8.2.
- Reconciling the Accounts Receivable system to the general ledger prior to review by the Accountancy Manager.

6.4 Accounts Receivable Officers

Are responsible for:

- Checking all manual income requests received for correct completion, authorisation and VAT treatment.
- Raising invoices and credit notes from all requests received and either mailing hard copies in the post or emailing within 24 hours of production.
- Producing and sending 1st and 2nd Dunning letters on a twice weekly basis.

- Liaising with customers and payroll services re setting up payment plans for payment of invoices by instalment and dealing with any queries raised
- Production of a monthly schedule of outstanding invoices by budget holder, distribution and collation of responses.

6.5 Treasury Officers

Are responsible for:

- Receipting all cash received by the Health Board in payment of invoices raised and apply to the appropriate invoice in the ledger.
- Liaising with the Accounts Receivable Manager re any unapplied amounts to clear them and repay if necessary.

6.6 Accountancy Officer

Is responsible for:

- Receipting payments received via deduction from salary to the customer account against the invoice raised in the ledger.

6.7 Accountancy Manager

Is responsible for:

- Reconciling on a monthly basis, the Accounts Receivable system with the balance per the General Ledger.

6.8 Payroll Department

Is responsible for:

- Submission of timely income requests and the associated backing documents in relation to overpayments of salary, travel expenses and other payroll related payments. Submissions via payroll are made through the NWSSP – Overpayments Platform.
- Responding to queries from employees regarding salary related overpayments to facilitate prompt payment of invoices. Further detail regarding Payroll responsibilities can be found in the Recovery of Overpayment to Employees procedure.

7 Accounts Receivable

All income due to the Health Board which is not collected at the point of service or sale is:

- Invoiced to the appropriate debtor promptly and in accordance with agreed tariffs and other charging arrangements.
- Accounted for in the reporting period to which the income relates.
- Properly pursued with adequate arrangements for the collection of income due.

Invoices must be raised for all types of income due, except where alternative arrangements are in place or where the income has been collected at the time of service or sale.

The charges to be applied will be as determined by:

- Guidance issued by the Welsh Government, the National Health Management Executive or any other government department.
- Rates determined or agreements reached locally by officers of Aneurin Bevan University Health Board.

The Recovery of Overpayments to Employees procedure should be read in conjunction with this procedure in relation to the recovery of debts related to overpayments made via the salaries and wages system for staff.

An All-Wales NWSSP Overpayments procedure is currently being developed, which will sit alongside the local Health Board's procedure.

Bills that are not paid in accordance with the procedure set out for timely recovery of debts will be referred to the Aneurin Bevan University Health Board's debt collection agency and in the event of continued non-payment will be considered for civil court action for debt recovery where cost effective to do so and based on the advice of the Health Boards debt collection agency.

Separate procedures are in place for Welsh NHS bodies and other public bodies.

To maintain internal control, Officers responsible for the Accounting and Control of Accounts Receivable should not also receive and account for cash or cheques

7.1 Procedure for requesting and raising an Invoice

7.1.1 The sources of information to enable an Accounts Receivable account to be raised are:

- An Income Request Form (Appendix A)
- Auto-Invoicing
- NWSSP - Overpayments Platform

7.1.2 All requests to raise an invoice by Managers, who are responsible for notification of income due, must be forwarded to the Accounts Receivable department by one of the sources identified in Paragraph 7.1.1 above and must contain the following information:

- Name and telephone extension number of the requesting officer
- The full name and address, including the postcode, of the debtor
- If the debtor is a company or other organisation, the name of the person to whom the invoice should be directed.
- The Oracle customer number for the debtor, if known
- A telephone number, and email address if possible
- Full details of the charge to be made, together with any appropriate backing documentation.
- A valid Purchase Order number from the customer, in line with All Wales No PO No Pay, where applicable.
- The amount to be billed, with VAT applicable shown separately
- The financial code to which the income is to be credited.
- Named individual within ABUHB to be contacted in the event of a query on the invoice (FAO), including contact number and/or email address.

7.1.3 When invoices are raised, managers must ensure that there is appropriate documentation available to support any agreements for goods and services provided to the customer. This documentation must be issued to the Financial Services Manager – VAT, to ensure the correct VAT treatment has been applied, prior to the invoice being raised. This will minimise later payment disputes. To this end this policy ensures that the manager who initiates the invoice will be engaged in the resolution of disputes when invoices are not promptly paid.

7.1.4 All requests for an invoice to be raised must be authorised by the requesting officer (other than Auto-Invoicing) and forwarded to the Accounts Receivable department for action.

7.1.5 The Accounts Receivable department will be responsible for ensuring that invoices are raised for all requests of income due to the Aneurin Bevan University Health Board.

7.1.6 On receipt of the Income Request form (See Appendix A), the Accounts Receivable Manager, or Accounts Receivable Officer should ensure that the form is correctly completed and authorised

by the requesting officer. Incomplete or unsigned requests are to be returned to the originator for completion (There is no requirement for this with Auto-Invoicing). The Officers should also check the correct treatment of VAT is indicated on the form and inform the originator where this is different. A customer number is then allocated and documented on the requisition form.

7.1.7 The Income Request forms or other sources as per paragraph 7.1.1 are sorted by the Accounts Receivable Officer, and sequentially numbered (requisition number). The total of this batch is to be calculated and entered on to the Batch Control Register.

7.1.8 The information from each batch of Income Request forms, or other sources as per paragraph 7.1.1, shall be input into the Oracle Accounts Receivable system. After inputting each request in the Oracle Accounts Receivable system, the Accounts Receivable Officer is to enter the date invoice is raised and the invoice number on to the Income Request form or other source of notification, and stored electronically.

7.1.9 On completion of the batch, a batch header shall be generated, detailing control value and number of invoices raised.

7.1.10 The Accounts Receivable Officer should complete a batch header and check that the batch totals reconcile to the Batch Control Register.

7.1.11 The batch header, hard copy invoices and original income request form should be passed to and checked by a member of the Accounts Receivable department, other than the person inputting the Income Request Forms to which the batch relates. Appropriate action should be taken for any invoices where discrepancies to the Income Request Form are identified. The officer checking accuracy should sign the batch header.

7.1.12 The Invoices should be dispatched to the debtor within 24 hours of production. Hard copies of invoices are not kept in the office but may be reprinted from the Oracle Accounts receivable system at any point in time.

7.1.13 The Income Request Forms are scanned (with any associated Backing documentation) to the Invoice on the Oracle Accounts Receivable module. All Income Request Forms in a single Batch are scanned to the Batch Header, and an electronic copy is retained. Hard copy requests are no longer retained.

7.1.14 The Health Board has implemented the Auto-Invoicing process within some departments to facilitate the raising of invoices.

Auto-Invoicing uses an interface to upload invoices directly into the Oracle Accounts Receivable system, through a template. The correct completion of the template is the responsibility of CMA. The information on the auto-invoicing template should match the detail required on the invoice request form, as detailed in 7.1.2. Once the template is complete and validated, it is transferred into Oracle by the Accounts Receivable Officer and a new Batch of invoices is created.

The Accounts Receivable team will be notified by CMA, via email, that a new batch of invoices is ready to be imported into Oracle. The email will include the total number of invoices in the batch, the total batch value, and the file name of the batch. The Accounts Receivable team will ensure that the batch is imported into Oracle successfully, and the invoices are printed or emailed and sent to the customers.

The Accounts Receivable team will notify the requester, via return email, of the success of the batch, confirming the total number of invoices raised, and the total value of the batch.

If there are any issues with the batch, the batch will be cancelled by the Accounts Receivable team and returned to the requesting officer for review. The batch will then need to be reviewed, amended as required and re-entered as a completely new batch.

The full Auto-Invoicing procedure details the step-by-step guide for implementing Auto-Invoicing (Accounts Receivable – Auto Invoice Process).

7.1.15 The NWSSP – Payroll department have developed an overpayments platform to monitor and raise overpayments of salary. When an overpayment of salary has been calculated, the Payroll department will complete a Microsoft Form which is reviewed and verified by a Senior Payroll Officer, before being submitted and uploaded to the NWSSP – Overpayments Platform.

In the first instance the Payroll Team will refer an overpayment to the ABUHB Counter Fraud Team for consideration where the overpayment is over £5k and/or longer than three months in duration. The Payroll Team will only proceed with an overpayment notification on confirmation that ABUHB Counter Fraud Team give an instruction to continue with the overpayment process.

The submission of a new overpayment onto the platform sends a notification to the Accounts Receivable team via TEAMS, that a new income request has been created and uploaded to the platform.

The Accounts Receivable team then utilise the detailed information on the platform to raise a new invoice for the overpayment of salary as per the process described above.

The invoice, alongside the associated Overpayment of Salary letter from the NWSSP – Payroll Services department and backing information will then be sent out to the recipient.

Once the invoice has been raised, the Accounts Receivable team update the Overpayments Platform to confirm the invoice number and date of issue.

The NWSSP - Overpayments Platform is available to the Workforce team, in the form of a BI Reporting Tool, who are able to review the reason, department, manager and value of all overpayments that have occurred throughout the Health Board.

7.2 Notification of Payments

7.2.1 Hospital Cashiers/Finance Cashiers who receive payment of an invoice are to record as much detail as possible on the Cash Receipts and Bank Deposit (C & D) sheet and always the invoice number if available. These entries must be coded to the Accounts Receivable control code. The officer receipting cash only has write access to the receipting, with view only access to other Accounts Receivable functions.

7.2.2 The Finance Cashier will produce a receipt batch print identifying all receipts received and where appropriate the Accounts Receivable invoice number the amount has been applied to.

7.2.3 Cash receipts received that are unable to be allocated to an invoice number will be receipted against the unapplied code .This will also apply to credit transfers. Copies of the relevant statements and/or remittance advice shall be made available to the Accounts Receivable Manager by the Cashiers department for reconciliation of the unapplied receipts register.

7.2.4 The appropriate Finance Officer in Financial Accounts shall receipt payments obtained via deductions from salary to the customer account (accounts receivable receipt code). A copy of the deductions list should be forwarded to the Accounts Receivable Manager from the Payroll Manager.

7.2.5 The Cashiers Department will enter the payments received for invoices, from all sources into the Oracle Accounts Receivable system, through the receipting module.

7.2.6 Any payments received that differ in value from the invoice raised are to be investigated by the Cashiers department / Accounts Receivable Manager and the appropriate action taken to clear these amounts. All refunds to be processed using the debit memo functionality in Oracle and processed via Accounts Payable.

7.2.7 On completion of the posting of each batch of receipts, the Cashier shall produce a receipt register. This should be filed and where appropriate the paying in slip attached.

7.2.8 The amounts posted against the computerised Accounts Receivable system must be reconciled on a monthly basis with the amounts coded to Accounts Receivable receipts in the general ledger. The Assistant Head of Financial Accounting should undertake the Accounts Receivable reconciliation. This officer should not have access to be able to post receipts on the Oracle Accounts

Receivable system. The Accounts Receivable Reconciliation should be checked and authorised by the Assistant Head of Financial Services and Accounting. Any discrepancies should be investigated and cleared by the Accountancy Manager.

7.2.9 The Head of Financial Services and Accounting will have access rights to all Oracle functionality in order to ensure that operational issues are resolved quickly.

7.3 Requesting and issuing of Credit Notes

7.3.1 Any credit note requested must be authorised by the requisitioner that requested the original invoice to be raised, and it is their responsibility to inform the Accounts Receivable department when there is a need to amend or cancel an invoice.

All requests for a credit note to be raised must be authorised by the requesting officer (other than internal e-mail requests or for Auto-Invoicing) and forwarded to the Accounts Receivable department for action.

7.3.2 All requests to amend or cancel an invoice must be made on a Credit Note Request Form (Appendix B) or by E Mail.

7.3.3 The following details must be stated on the Credit Note Request Form by the authorised requesting officer:

- Name and telephone extension number of the requesting officer
- The Invoice Number
- Customer Number
- The Original Invoice Value
- The Credit Note Value
- The Revised Invoice Value
- The reason for amending or cancelling the invoice
- The Financial code to be debited

7.3.4 On receipt of the Credit Note Request Form, the Accounts Receivable Manager or Accounts Receivable Officer should ensure that the form is correctly completed and authorised by the requesting officer. Incomplete or unauthorised requests are to be returned to the originator for completion. (There is no requirement for this with Auto-Invoicing).

7.3.5 An officer within the Accounts Receivable department will sort the Credit Note Request Forms. The credits are checked for Customer numbers and that the amount to be credited is still outstanding on the ledger.

7.3.6 The information from each batch of Credit Note Request Forms shall be input into the Oracle Accounts Receivable system. After inputting each request, the Accounts Receivable Officer is to enter the Credit Note Number and the date actioned on the Credit Note Request Form and sign it.

7.3.7 On completion of the batch, hard copies of the credit invoices are printed prior to dispatch. Appropriate action should be taken for any amendments or cancellations deemed to be incorrect by the Accounts Receivable Manager.

7.3.8 The Accounts Receivable manager applies the credit to the appropriate invoice then checks the credit notes.

7.3.9 The Credit Notes are shown as an individual document. The original invoice and credit notes are printed and dispatched as appropriate. Hard copies of credit notes are not kept in the office but may be reprinted from the Oracle system at any point in time.

7.3.10 The batch header document, and any supporting documentation are scanned and filed electronically per batch.

7.4 Debt Collection – Treatment of Invoices Unpaid

7.4.1 The standard debt collection process is as follows:

7.4.1.1 On a twice weekly basis a 1st Dunning letter will be sent out to the individual for any invoice which remains outstanding for 21 days from the date of the invoice (See Appendix C).

7.4.1.2 Where no response has been received to Dunning letter 1 (as above), after a further 21 days a 2nd and final Dunning letter is issued to the individual stating that after 14 days the Debt will be referred to The Health Board Debt Collection Agency.(See Appendix D)

7.4.1.3 At the same time as the second Dunning letter is issued, the requesting manager is also contacted to help facilitate the process and inform of any disputes that may have arisen with the Customer.

7.4.1.4 If payment is not received within 14 days of the second Dunning letter, there is no further information, or the manager has not replied, the Accounts Receivable manager will refer the debt to the Health Boards Debt collection agency for them to pursue the debt on behalf of the Health Board.

7.4.1.5 On a monthly basis all debts outstanding and referred to the debt collecting agency will be reviewed in a meeting with the Assistant Head of Financial Services, Treasury Manager and Accounts Receivable Manager. A decision will be taken on whether to refer any outstanding debts for court referral. This referral will be based on the debt collection agency's advice and likelihood of court action success. Where necessary, decisions will be escalated to the Head of Financial Services & Accounting.

7.4.2 Exceptions to the standard process:

7.4.2.1 The Recovery of Overpayments to Employees procedure should be read in conjunction with this procedure, For other outstanding debts relating to Health Board employees and former Health Board Employees e.g. mobile phones, lease cars, the standard debt collection procedure will be applied..
An All-Wales NWSSP Overpayments procedure is currently being created, which will sit alongside the Health Board's local procedure.

7.4.2.2 NHS Organisations – Welsh – All Welsh NHS bodies are subject to the arbitration process set out by Welsh Government and must adhere to this policy when chasing outstanding debts. The Welsh

Health Circular (WHC (2022) 013) detailing the roles and responsibilities of each NHS Wales Organisation is updated on a bi-annual basis.

7.4.2.3 NHS organisations Non Welsh – Statements and copy invoices are sent monthly. A list of all outstanding invoices will also be sent to the requestor, to inform them of the outstanding debt, and help facilitate any disputes. The Accounts Receivable Manager will also contact the NHS organisation concerned by email or telephone to ascertain the reason for non-payment providing the invoice has not been raised in error, telephone calls or email contact shall continue until such a time as the invoice is settled.

7.4.2.4 Other Public Bodies

The procedure for the collection of debts from other public bodies is laid out in Appendix E & F.

7.4.2.5 Research & Development Invoices

Standard Research & Development contracts include 45 day payment terms.

On a twice weekly basis a final Dunning letter will be sent out to the debtor for any invoice which remains outstanding for 45 days from the date of the invoice (See Appendix D). This letter states that after 14 days the debt will be referred to The Health Board Debt Collection Agency.

At the same time as the second Dunning letter is issued, the requesting manager is also contacted to help facilitate the process and inform of any disputes that may have arisen with the customer.

If payment is not received within 14 days of the second Dunning letter or there is no further information, or the manager has not replied the Accounts Receivable manager will refer the debt to the Health Boards Debt collection agency for them to pursue the debt on behalf of the Health Board.

7.4.2.6Reporting of Overseas Visitors Outstanding Debts.

As per the Overseas Visitors procedure, the Health Board is responsible for raising invoices to patients identified as overseas visitors. .

The Health Board is also required to report any outstanding debt to the Department of Health & Social Care (DHSC).

On a monthly basis the Treasury Manager is responsible for reviewing all outstanding debt identified in this category and updating, as required, any changes in debt status that have been identified.

This includes notifying DHSC of:

- new debts raised that exceed the reporting threshold (£500),
- updating debts that have been paid in full,
- updating debts where a repayment plan has been agreed,
- any other changes to the debt status.

7.5 The Health Board's Debt Collection Agency

7.5.1 All debts referred to the Aneurin Bevan University Health Board's Debt Collection agency should be referred as per the signed agreement between Aneurin Bevan University Health Board and the contracted Debt Collection Agency.

7.5.2 The contracted Debt Collection Agency undertake to:

- Approach debtors referred by letter, email and telephone only.
- Provide progress reports on each case.
- Remit all monies collected promptly.
- Charge for successful UK recovery services.
- Seek approval in advance for any "in person" site visits to debtors.

7.5.3 The Aneurin Bevan University Health Board undertakes to:

- Pay contracted Debt Collection Agency for all agreed services rendered and within agreed time limits as detailed on the supplier invoice.
- Provide any information requested by the contracted Debt Collection Agency, if possible.
- Inform the contracted Debt Collection Agency of any payments which have been received by the Local Health Board, in respect of invoices referred to them.
- Inform the contracted Debt Collection Agency on the Local Health Board's agreed courses of action in respect of any debts referred to them, when necessary.

7.6 Payment by Instalments

7.6.1 Any enquiry to pay by instalments will be reviewed by the Treasury Manager and Assistant Head of Financial Services.

Payments by instalments, where possible, shall be limited to a period of 12 months and should be by standing order or payroll deductions. Where there are special circumstances, the period, amount payable by instalment, and method shall be at the discretion of the Assistant Head of Financial Services. (In the absence of the Assistant Head of Financial Services, the decision will be made by the Head of Financial Services and Accounting.)

Where customers have requested to pay by instalments, the Health Board will issue an invoice for an Administration Charge of £1 per month for every month of instalment.

7.6.2 In the case of overpayments of salary, where payments by instalments are requested, the recovery of Overpayments to Employees procedure should be followed (see section 7.4)
An All-Wales NWSSP Overpayments procedure is currently being created, which will sit alongside the Health Board's local procedure.

7.6.3 The Health Board will issue an invoice for an Administration Charge of £1 per month for every month of instalment from the end of the 'matching period.'

7.7 Court Action

7.7.1 If all attempts to recover the debt via the usual follow-up procedure have failed consideration shall be given to take the debtor to court. The decision on whether to take this course of action shall depend on:

- The circumstances of the debt and the likely success. Advice from the Local Health Board's Debt Collection Agency shall be taken into account.
- The value of the debt.

7.7.2 The decision on whether to apply for court action shall rest with the Head of Financial Services and Accounting.

7.8 Write Off Procedure

7.8.1 Only Non NHS invoices can be written off. The NHS Manual for Accounts states that NHS Debts cannot be written off. If an NHS Debtor refuses to settle an account, negotiations should take place in an attempt to resolve the disputed amount in line with the Welsh Government Arbitration procedure which all Welsh NHS bodies

must adhere to. For all English NHS disputed invoices meetings should be held with the appropriate parties to reach a satisfactory conclusion.

7.8.2 Those Non NHS Invoices which are proposed for write off should be detailed on a schedule prepared by the Accounts Receivable Manager. The Accounts Receivable Manager, on a bi-monthly basis, will review outstanding debts that have been classed as a "Bad-Debt", and prepare a schedule, providing the following information:

- Invoice Number
- Invoice Date
- Invoice Type, e.g. Private Patient, Prescription Charge
- Debtor Name
- Original Amount with VAT identified separately
- Amount Outstanding with VAT identified separately
- Reason for the Write off

7.8.3 The Health Board has introduced an Approval Hierarchy, based on the value of the bad debt that is proposed for write off. The Approval Hierarchy is as follows, and contains 6 Authorisation levels:

Authorisation Level	Responsible Officer	Lower Limit	Upper Limit
1	Assistant Head of Financial Services	£0	£10
2	Head of Financial Services & Accounting	£10	£50
3	Assistant Director of Finance (Financial Systems & Services)	£50	£2,500
4	Executive Director of Finance	£2,500	£25,000
5	Audit Committee	£25,000	£50,000
6	Welsh Government	£50,000	No Upper Limit

7.8.4 The Accounts Receivable Manager will prepare a schedule with proposed write-offs for each Approval Level. Each schedule will be sent to Assistant Head of Financial Services, who will then review the proposed write-offs, and provide approval as appropriate.

7.8.5 For those write-offs that require further approval (i.e. Write-offs over £10), the schedule will be sent to each Responsible Officer in the Approval Hierarchy in turn, based on the value of the debt.

For example, if there is a debt of £1,000 proposed for write-off, the Assistant Head of Financial Services and Head of Financial Services and Accounting will review and approve the write off in turn, before

it is sent to the Assistant Director of Finance (Financial Systems & Services) for final approval.

7.8.6 Once final approval for each debt has been provided, the write-offs can be processed on the system by the Accounts Receivable Manager, who will receive the signed certification from the final authoriser.

7.8.7 The debts which have been approved for write-off will be reported to the Audit Committee on a periodic basis, detailing the total number of debts per authorisation level, and the total value of the debts.

7.8.8 Invoices will only be put forward for write off once every option for recovering the debt has been pursued and where the Health Board's debt collectors have recommended that court action is not viable.

8 Implementation

This document should be implemented with immediate effect.

9 Further Information

Enquiries regarding this policy should be directed to the Treasury Manager, Assistant Head of Financial Services, Head of Financial Services and Accounting or the Assistant Director of Finance (Finance Systems and Services).

10 Audit

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

11 Review

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

Appendix A

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

INCOME REQUEST FORM

*** For Attention Of:**	
*** Customer Name:**	
Customer Email:	
Customer Telephone:	
*** Customer Address:**	
*** Post Code:**	
Purchase Order Number	

*** Please Tick as Appropriate:**

Invoice to be Sent out Direct	
Invoice to be returned to Requesting Officer	
Backing information to be sent out	

Details to Appear on Invoice:

	*** Line Description**	*** VAT**	*** Value £**
1			
2			
3			
4			

*** Account Code for Invoice to be raised:**

Entity	Cost Centre	Subjective	Analysis	Unit	VAT	Value £
040						
040						
040						
040						

*** Requesting Officer:**	
*** Contact Telephone:**	
*** Contact Email:**	
*** Signed:**	
*** Budget Holder Name:**	
*** Signed:**	
*** Date:**	

Accounts Receivable Use Only:

Account Number:	
Date Raised:	
Invoice Number:	

* Fields marked with * are mandatory

Appendix B

Credit Note Request

FROM:

TO: ACCOUNTS RECEIVABLE, FINANCE DEPARTMENT,

C BLOCK, MAMHILAD PARK EST, PONTYPOOL.PLEASE WOULD YOU ISSUE A CREDIT NOTE AGAINST THE FOLLOWING INVOICE:

INVOICE NO.: _____ DATE RAISED:_____

NAME OF DEBTOR: _____

CUSTOMER NO: _____

	AMOUNT	
	£	p
ORIGINAL INVOICE VALUE:		
CREDIT NOTE VALUE:		
REVISED INVOICE VALUE:		

REASON FOR ISSUING CREDIT NOTE

SIGNED: _ DATE: _____

THIS REQUEST MUST BE APPROVEDY A SENIOR MANAGER

ACCOUNTING CODE					Amount		For Debtors Section Use Only
					£	P	
040							**Credit Note Number**:
040							
040							**Date Actioned**:
040							
040							**Signed**:
040							

Appendix C

1st Dunning Letter

Appendix D

2nd Dunning Letter

Appendix E

Disputed Debts between ABUHB and Local Authorities

Summary

1. This guidance is intended to facilitate the resolution of invoices in dispute between the ABHB and the Local Authorities.

2. The implementation timetable has been designed to ensure that no debts remain outstanding for more than 56 days. This procedure will apply to all invoices regardless of the value.

3. The Health Board has issued a revised debt chasing procedure whereby Managers (authorised signatories) are asked to chase debts if they remain outstanding for more than the allocated payment period of 21days.

4. It is anticipated that most debts will be agreed and paid within this timeframe and that this procedure will only apply to any invoices where disputes are notified regarding the value or period that the invoice covers.

Scope

5. This procedure will apply to all Welsh Local Authorities.

Procedure & Implementation

6. The timetable for action in relation to disputed debts is outlined below:

Age of Debt (days)	Action	Responsibility
0-21	Invoice raised and awaiting payment.	Requisitioner and Accounts receivable Staff.
22 (1st Dunning letter)	1st dunning letter sent to debtor chasing payment. Authorised signatory/Manager to be notified of the outstanding debt for them to liaise with their counterpart in the billed organisation to secure payment.	AR staff and Authorised signatories/Managers.
44 (2nd Dunning letter)	2nd level dunning letter sent chasing payment and notification of referral to DoF after 14 days if the invoice remains unpaid. Authorised signatory/ manager to establish when invoice will be paid or to resolve any outstanding disputes to facilitate the payment of the invoice.	AR staff and Authorised signatories/managers.

56+	Refer to the Director of Finance if no information has been received from the Manager to say otherwise. Failing this consider court action.	Director of Finance to be notified of non-payment to contact counterpart in billed organisation to reach agreement and invoice paid.

Appendix F

Government Bodies Escalation Process Submission Proforma

Submitting Organisation:
Creditor Organisation:
Debtor Organisation:
Invoice Date:
Invoice Ref:
Invoice Amount:
Reason for Invoice:
Evidence of verbal discussions between parties: **Confirm if included within Attachment or Within Main Case Section**
Evidence of written discussions between Chief Executives: **Confirm included within Attachment**
Case Submission Date:
Director of Finance Signature:



Aneurin Bevan University Health Board

Counter Fraud Communication Strategy

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

Status: DRAFT
Approved by: Audit Committee

Issue date: DRAFT
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1. Introduction

1.1 This Communication Strategy has been established to enable and support communication and engagement to promote and raise awareness of the NHS counter fraud initiative, including the publicising of proven NHS fraud cases and media handling within and outside the Health Board.

1.2 The Local Counter Fraud Specialist (LCFS) is committed to ensuring that effective communication is undertaken to deter fraud and prevent the organisation from falling victim to fraudulent practices which divert much needed NHS resources from patient care. Through publicity, education and training, the organisation seeks to change attitudes to and perceptions of NHS fraud. The message will be that fraud is not a victimless crime and that active co-operation of all is necessary to prevent valuable resources being diverted through fraudulent activity.

1.3 The LCFS will work with staff who already have effective communication approaches in place which may be used to publicise, educate, and train staff throughout the organisation.

1.4 The types of communication used by the LCFS will be reported to both the Director of Finance, Procurement & Value and the Audit, Risk and Assurance Committee, along with assessments of how effective this work has been.

1.5 The Communication Strategy concentrates on the following communication areas:

- Media and External Awareness Raising
- Local promotion of fraud awareness within all areas of the Health Board.

1.6 The Director of Finance, Procurement & Value should be consulted about any conflicts that arise in respect of this communications strategy. The Assistant Director of Communications and Engagement will also be consulted on communication approaches.

1.7 This communications strategy is open to review and continual improvement, particularly in light of further experience and new developments. Countering fraud will require a comprehensive approach from everyone who works in and around the organisation.

2. Background

Welsh Government Directions to NHS Bodies on Counter Fraud Measures outline the need for due regard to be paid to any guidance and advice on media handling of counter fraud matters issued by the NHS Counter Fraud Authority (NHSCFA).

2.2 The Chartered Institute of Public Finance and Accountancy (CIPFA) strategy document *'Managing the Risk of Fraud'* identifies the need for the organisation to have a clear programme of work to publicise the role of the LCFS and sanctions imposed on proven perpetrators of NHS fraud.

2.3 The NHS anti-fraud manual identifies three key principles of action. The first key principle for NHS anti-crime work involves the creation and development of an anti-fraud culture. This is achieved by proactive work to inform and involve those who work for or use the NHS about economic crime, how to tackle it, with a view to increasing understanding of the impact of economic crime against the NHS. To create such a culture, there needs to be effective communication about the LCFS role and sanctions imposed for proven perpetrators of NHS fraud so that potential fraud is deterred. This can be accomplished through communications and promotions such as public awareness campaigns or through media engagement to change the culture and perceptions around economic crime so that it is not tolerated at any level.

3. Communicating with the Media

The Assistant Director of Communications and Engagement or Head of Communications will receive an advance warning from the LCFS if there is a possibility of external interest in any potential fraud investigation or fraud awareness event. Appropriate measures may need to be put in place to protect the organisation from adverse publicity and ensure continuity of patient services/care.

3.2 The Assistant Director of Communications and Engagement and/or Head of Communications should contact the NHS Counter Fraud Authority media team when formulating a press response in relation to fraud and corruption issues. This is because the request for information is likely to impact on both organisations.

3.3 All press releases relating to fraud and corruption will initially be agreed with the Assistant Director of Communications and Engagement and/or Head of Communications in liaison with the LCFS and NHS Counter Fraud Authority. Such communications allow members of the public to become aware of the anti-fraud initiative and the role of the LCFS.

3.4 The NHS Counter Fraud Authority will promptly brief the Assistant Director of Communications and Engagement and/or Head of Communications on any other contentious issue in relation to fraud and corruption which is likely to attract interest from the media. Public interest/safety should always be the ultimate consideration when deciding whether to be proactive in these circumstances by releasing information or issuing a reactive statement.

3.5 Despite best efforts, the media may become aware of inappropriate information about an ongoing fraud or corruption investigation. If this situation does occur, it can sometimes result in the media running inaccurate stories about investigations. In such cases, the Director of Finance, Procurement & Value should be contacted immediately so that, in liaison with the NHS Counter Fraud Authority, the best course of action can be determined. The NHS Fraud Authority/Health Board/LCFS will need to liaise closely to ensure that resulting stories are not misrepresentative or damaging to the investigation or reputation of the organisations and people involved.

3.6 Any media enquiry about fraud or corruption received by the LCFS will be directed to the Assistant Director of Communications and Engagement and/or Head of Communications in the first instance. This will ensure a consistent approach across the Health Board.

3.7 Any request to the LCFS for a media interview will be directed to the Assistant Director of Communications and Engagement and/or Head of Communications, ensuring that it is handled promptly, and the most appropriate person interviewed. Requested media interviews about the LCFS role, etc will be notified to the Assistant Director of Communications and Engagement and/or Head of

Communications as a matter of courtesy in case there is further interest from other media groups.

4. Local Promotion of Fraud Awareness

To promote the role of the LCFS and create an anti-fraud culture, the LCFS will use various communication methods around the organisation. These will inform, educate, and train staff, patients and visitors about the effect fraud can have on patient care and how to report any knowledge or suspicions of potentially fraudulent activity.

4.2 The communications undertaken by the LCFS are designed to cover the following areas:

- **Inform and involve** – this involves working with NHS staff, stakeholders, and the public to change the attitudes to and perceptions of fraud within the organisation so that there is a willingness, and confidence, to report any knowledge or suspicion of fraud. The need to protect the organisation from fraudulent activity needs to be seen as the joint responsibility of everyone within the organisation. The aim is to highlight the risks and consequences of crime against the NHS.
- **Prevent and Deter** – This sets out the requirements in relation to discouraging individuals who may be tempted to commit crimes against the NHS by ensuring that opportunities for crime to occur are minimised. It also includes ensuring that systems being operated are not open to fraud occurring unchallenged or undetected. It involves raising awareness of the types of fraud that may occur and communicating this to line managers, budget holders, risk groups, audit committees and auditors of organisations. Deterrence is linked to the creation of an anti-fraud culture in that peer group pressure can make potential fraudsters feel that what they are contemplating is unacceptable. The deterrent factor is about the extent to which potential fraudsters believe that if fraud is attempted it will be detected and prevented from succeeding. It also relies on communicating the message that full sanctions (including criminal action) will be considered, without exemption, and appropriate action taken against any perpetrator of NHS fraud.
- **Hold to Account** – This incorporates the requirements in relation to detecting and investigating crime, prosecuting

those who have committed crimes and seeking redress. It involves enforcing the message for all staff to remain vigilant and open to the possibility of fraud being attempted. The LCFS will need to communicate to all staff what action to take if a potential fraud has been detected, as inappropriate, well-intentioned actions may compromise the pursuit of full sanctions if fraud can be evidenced. This type of communication needs to emphasise Health Board support for staff who report such concerns so that confidence in the system can be maintained. To underpin the above messages, the LCFS will publicise proven cases of NHS fraud that has occurred both locally and nationally. Communication in this area enhances the message that fraud within the NHS will not be tolerated and that the organisation, and NHS, will pursue full sanctions whenever appropriate to do so.

- **Strategic Governance** – This sets out the standards in relation to the organisation's strategic governance arrangements. The aim is to ensure that anti-crime measures are embedded at all levels across the organisation.

4.3 The effectiveness of the communication methods explained in 4.2 will be assessed by using a local annual staff survey issued to a sample of staff across the organisation. The results of this survey will be reported to the Director of Finance, Procurement & Value and will inform future work undertaken by the LCFS.

4.4 Appendix 1 details the communication methods and action plans to meet specific target audiences. Any other types of communication available around the organisation should be brought to the attention of the LCFS so that they can be added to the appendix.

5. Contact Points

5.1 Any concerns about work related to fraud and corruption should be communicated to the LCFS, who can be contacted on **01495 765470** or email **CounterFraud.ABB@wales.nhs.uk**

5.2 There is also the NHS Fraud and Corruption Reporting Line on **0800 028 40 60** to which knowledge or suspicion of NHS fraud can be reported (anonymously if preferred) or likewise via the online reporting tool **www.reportnhsfraud.nhs.uk**

5.3 The NHS Counter Fraud Authority media team can be contacted via email on media@nhscfa.gov.uk

5.4 Further information can be found on the Local Counter Fraud intranet site, in its Raising Concerns Policy, Counter Fraud Bribery and Corruption Policy, or from the NHS Counter Fraud Authority

Appendix 1 Internal/External Communication Opportunities

Target Audience	Key Messages	Actions	Frequency	Responsibility
Health Board	Demonstrate that the Board is accountable for fraud in the NHS	Message from Chief Executive to be included in board briefing	1 per annum	LCFS & Director of Finance, Procurement & Value
Audit, Risk and Assurance Committee	Update the committee on progress of the Counter Fraud work plan	Regular update reports for the Audit, Risk and Assurance Committee	4 per annum (Quarterly updates)	LCFS
		Annual Report including compliance with the Welsh Government directions	1 per annum	LCFS
New Staff	Promote the role of the LCFS	Fraud Awareness presentation included in Induction programme	12 per annum	LCFS & Training & Development
		Information included in Induction packs	Packs to be updated Annually	LCFS & Training & Development
All Staff	Promote the role of the LCFS Publicise Successful local and national cases	Include article in Team Brief	1 article per annum	LCFS & Assistant Director of Communications and Engagement and/or Head of Communications
		Include article in specialist newsletter	Target higher risk groups 1 article per annum	LCFS

Target Audience	Key Messages	Actions	Frequency	Responsibility
		Include in customised fraud awareness presentations (Departmental)	As required	LCFS & Department Managers
		Include in Counter Fraud newsletter	As required	LCFS & Assistant Director of Communications and Engagement and/or Head of Communications
		Counter Fraud webpage included on staff intranet	Information to be updated monthly	LCFS & IT
Managers & Supervisors	Risks of Fraud	Fraud Alerts	As required	LCFS & Assistant Director of Communications and Engagement and/or Head of Communications
		If Key risk identified meeting to be held with Manager responsible	As required	LCFS & Department Managers & Supervisors
		Regular meeting with Risk group	To be agreed (Risk group to be identified)	LCFS & Risk Manager & Supervisor
Staff, Visitors & Patients	Encourage people to report fraud suspicions	Counter Fraud posters & leaflets on display at various locations	Walk around to replenish stock x 2 per annum	LCFS

Target Audience	Key Messages	Actions	Frequency	Responsibility
	Give positive image that NHS are dealing with fraud	Event to be organised in conjunction with fraud awareness programme	3 per annum	LCFS
NHS Contractors	Promote the role of the LCFS Publicise Successful local and national cases	Publicity Packs to be distributed (Posters & Leaflets)	1 per annum	LCFS
		Presentations to be delivered to Key Stakeholder groups	6 per annum	LCFS & Primary Care Director
		Newsletter to be circulated	2 per annum	LCFS

Aneurin Bevan University Health Board

Contract Management Financial Control Procedure

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Training **7**
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1. Introduction

This policy should be read in conjunction with the Procurement and Financial Control Procedure for Aneurin Bevan University Health Board (ABUHB).

A consistent approach to contract management is designed to ensure ABUHB's awarded contracts via third party suppliers are managed appropriately making best use of resources, mitigating against known risks and demonstrating value for money. Achieving this will deliver organisational benefits to ABUHB and help achieve contract compliance. This policy sets out the process contract managers should adhere to in order to meet the business, operational and policy objectives required from the contract.

2. Policy Statement

A significant proportion of the financial resources available to ABUHB are used to procure service delivery requirements from third parties. Contract management is the process and methodology which ensures that both parties, ABUHB and external providers, meet their contract obligations as efficiently and effectively as possible in order to meet the business, operational and policy objectives. It is important that ABUHB manage the third parties in a consistent, effective and professional manner whilst adhering to responsible and ethical behaviours.

Following procurement activity and a contract being placed with a third party, the contract and relationship needs to be managed to ensure that ABUHB receive the goods and services on the terms set out in the contract. The nominated contract manager in ABUHB is responsible for the management and performance of these contracts. All significant contracts for goods and/or services must be governed by either a contract specific service level agreement and through supplier performance measurement and reporting mechanisms.

The approach to contract management at ABUHB is based on proportionality and risk management. All Contracts which have an overall contract value greater than £100,000 (Inclusive of VAT and extension options) will have a designated contract manager within the budget holders business area. Other lower value contracts require to be reviewed by the budget holder to determine their business criticality through effective risk management. If these contracts are deemed to be high risk and business critical, there will be a designated contract manager.

For contracts with an overall contract value of greater than £100,000, a Contract Management Plan will be developed jointly by the Procurement Lead and the budget lead of the buying department. This plan will be used

to outline the roles and responsibilities, key aspects of the contract and the contract management provisions. It is the responsibility of the service contract manager to ensure the Contract Management Plan is updated regularly, throughout the life of the contract, detailing the changes and revisions to the contract and keep procurement informed of any updates or changes.

The contract manager must perform regular contract reviews to maximise operational performance, alignment to financial obligations, ensure social, economic and environmental benefits are met.

The Contract Management Plan will identify various elements including (but not limited to):

- ABUHB and 3rd Party lead contacts
- Timetable of delivery expectations and responsibilities
- Schedule of Suppliers meetings and memberships
- Communications Plan from the Contract Manager to key stakeholders
- Contract Objectives
- Benefits Realisation Plan
- Mobilisation Plan / Contract entry with timeframes
- Key Performance Indicators / Management Information Reporting
- Contract Variation Process
- Escalation process / procedures for non-delivery
- Opportunities for Continuous Improvement / Service Improvement / Innovation
- Exit Plan

Data Protection

With regards to GDPR, departments should work with the Information Governance team to ensure that a Data Protection Information Assessment (DPIA) is completed. The department will then work with Procurement to ensure the outcomes of the DPIA are considered within the strategy, requirements and the contract. The contract manager is then responsible for ensuring that GDPR requirements are followed in line with the contract and any issues or incidents are raised with the Information Governance team.

The department should work with Procurement to determine the level of Cyber Security risk at procurement planning stage. This level of risk then informs the requirements to be incorporated into the contract. It is the contract manager and data asset owners responsibility to monitor conformance with requirements, including accreditations being up to date. Any issues should be raised with the ABUHB IT Department and the Procurement team.

3. Aims

The purpose of this document ensures that ABUHB staff understand their role in managing contracts on behalf of the organisation and to encourage a consistent approach across the organisation to contract management.

4. Objectives

To outline contract management principles and provide guidance to contract managers on their role in managing contracts

5. Scope

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

- All ABUHB staff with budget responsibility
- All ABUHB staff with contract management responsibility
- All Procurement & Finance Staff

Separate NHS Wales Shared Services Partnership -Procurement Services (NWSSP-PS) procedures are in place for tendering and contracting so are not covered in detail in this document. Please contact NWSSP-PS for advice and support.

6. Roles and Responsibilities

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

The Director of Finance, Performance and Value is responsible for putting in place financial procedures to ensure that goods and services are duly authorised and comply with the Scheme of Delegation which sets out authority delegated by the ABUHB Executive Board.

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

ABUHB budget holders are responsible for contract management of the contracts which they use within their divisions. Procurement and finance teams will support contract management and can provide advice and training where required.

7. Contract Management in Aneurin Bevan

7.1 Contract Strategy

The ABUHB Procurement Team, in partnership with the nominated contract manager will develop a Contract Strategy for any procurement over £100k. For contract management, the strategy will serve as a reminder of key stakeholders involved during procurement, previous history of the contract, supply market analysis, risk management, sustainability, procurement route and a high-level plan for contract implementation and management.

7.1.1 Robust Terms & Conditions

NHS Wales operates on a set of standard Terms & Conditions which form part of the procurement documents to be issued and agreed with the successful supplier. Alongside the specification and tender response, terms and conditions are an agreement as to how the contract will operate. It is therefore important that contract managers have a working knowledge of the T&C's however, the Procurement and Legal & Risk team are able to support should any queries arise

7.1.2 Contract Award Recommendation Report

The ABUHB Procurement Team, in partnership with the nominated contract manager, will develop a Contract Award Recommendation Report for any procurement over £100k. This document summarises the procurement process and seeks approval for a contract to be awarded. From a contract management standpoint, it summarises the benefits of the proposed contract and any savings the contract is expected to deliver. Contract management is the process for then delivering these benefits.

7.1.3 Contract Management Plan

The ABUHB Procurement Team, in partnership with the nominated contract manager, will develop a Contract Management Plan. This is a key document in the move from the procurement process to contract implementation and management. The document details contract term, owners and their responsibilities, the level of contract management required, communication plans, contract objectives, mobilisation plan, performance management / governance, escalation, risks and exit plan.

7.1.4 Contract Performance Report

The contract manager should provide a performance report to procurement and relevant directors at agreed periods. This assists procurement in understanding what went well and any issues and can assist in the next iteration of the procurement. The Contract Performance Report should also include a risk register which is updated at regular intervals to be agreed in the contract management plan.

8. Resources

There are no financial or resource implications for the implementation of this document. There are a number of supporting documents and training resources which can be accessed by clicking the links below *(Links to be inserted once documents are live)*:

Contract Strategy
NHS Wales Standard Terms & Conditions
Contract Award Recommendation Report
Contract Management Plan
Procurement Policy and Financial Control Procedure

9. Training

Training is available for ABUHB nominated contract managers and is provided by Procurement and Finance Teams.

15. Audit

Contract Management in line with this policy is subject to internal audit.

16. Review

This document should be reviewed in 3 years from publication.

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

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

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The paper presents the Audit, Risk, and Assurance Committee (referred to as the Committee throughout the report) with an overview of all identified internal and external audit recommendations and current implementation status as at **31st March 2024.**

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

Cefndir / Background

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

Dashboard – Shows a whole picture of all live recommendations *Overdue and Not Yet Due reported on it Q4 **(Appendix 1**) We are committed to ensuring that there are no



long-standing overdue recommendations in the next iteration of the report that do not have revised deadlines.

Table 1 displays the number of overdue recommendations from audits conducted between the 2017-2021. Further details can be found at ***Appendix 2***

Table 1

All Longstanding (pre-2022) Overdue Recommendations as at 31 March 2024					
Year	**Priority Rating of Recommendation**				**Total**
	Low	Medium	High	N/A	
2017	**-**	**-**	**3**	**-**	**3**
2018	**-**	**-**	**-**	**-**	**-**
2019	**-**	**-**	**-**	**-**	**-**
2020	**-**	**-**	**-**	**4**	**4**
2021	**4**	**16**	**1**	**-**	**21**
Total	**4**	**16**	**4**	**4**	**28**

The data in Table 2 displays the number of overdue recommendations from audits conducted in the 2022/23 fiscal year. Further details can be found at ***Appendix 3***

Table 2

All Overdue Recommendations post 2022 financial year as of 31 March 2024					
Year	**Priority Rating of Recommendation**				**Total**
	Low	Medium	High	N/A	
2022	**12**	**24**	**4**	**2**	**42**
2023	**2**	**10**	**2**	**-**	**14**
2024	**3**	**15**	**14**	**-**	**32**
Total	**17**	**46**	**20**	**2**	**88**

The combined total for both tables **116** was the number of recommendations that required an update against, this is broken down in the main body of the report. Further details can be found at ***Appendix 2 and 3.***

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



Asesiad / Assessment

Internal and External Audit Recommendation Tracking.

Since the previous reporting period, 30th December 2023, work has been completed to update the master tracker to include all Internal and External Audit Recommendations up until the last Committee meeting on 8th February 2024.

The Committee has been provided with data regarding the status of all overdue and completed recommendations as at the 31st of March 2024 for this iteration of the report.

Following the previous reporting period, which ended on 30th December 2023, several revised timeframes were agreed upon, leaving a residual position of **12** overdue internal and external recommendations. A further **104** recommendations were triggered as overdue in **Q4** (December–March). In total **116** updates against overdue recommendations were requested.

The position reported in Table 3 reflects the position following updates received against all overdue recommendations up to 31st March 2024.

Table 3

Overview of Recommendation Activity for Quarter 1 Reporting Period											
Lead Director	Chief Operating Officer	Director of Corporate Governance	Director of Digital	Director of Finance	Director of Nursing	Director of Public Health	Director of Strategy, Planning, and partnerships	Director of Workforce and OD	Medical Director	Director of Therapies and Health Science.	Total
IA Overdue	18	9	18	-	13	-	3	-	1	1	**63**
EA Overdue	-	1	-	-	1	-	-	1	-	-	**3**
Revised Deadline	17	10	17	-	11	-	3	1	1	1	**61**
Completed	**25**	**2**	**5**	**-**	**3**	**-**	**11**	**1**	**-**	**3**	**50**

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

The position reported in this paper reflects the position as at 31st March 2024 in which there are **116 overdue** internal and external recommendations, of which, **61 of the 116** have been assigned a revised timescale for implementation for approval by the Committee and **50** have been **completed.**

If the committee approves the **61** revised deadlines the residual overdue position will be as follows:

- **5** Internal
- **0** External

The data in the summary tables (4-5) provide a breakdown of overdue and completed recommendations by the year of the audit.



Table 4 below summarises the position as at **31st March 2024** by the year of audit, in relation to the **66 (61** of the **66** have revised deadlines) **overdue** (past the original agreed-upon implementation date) Internal and External audit recommendations.

Table 4

Internal and External Overdue Audit Recommendations (*Revised deadline requests)					
Year	**Priority Rating of Recommendation**				**Total**
	Low	**Medium**	**High**	**N/A**	
2017	-	-	**1** *(*1)*	-	**1** *(*1)*
2018	-	-	-	-	
2019	-	-	-	-	
2020	-	-	-	**3** *(*3)*	**3** *(*3)*
2021	**3** *(*3)*	**15***(*15)*	**1** *(*1)*	**-**	**19** *(*19)*
2022	**9** *(*9)*	**17** *(*14)*	**2** *(*2)*	**2***(*2)*	**30** *(*27)*
2023	-	**3** *(*2)*	**2** *(*2)*	-	**5** *(*4)*
2024	-	**3** *(*2)*	**5** *(*5)*	-	**8** *(*7)*
Total	**12** *(*12)*	**38** *(*33)*	**11** *(*11)*	**5** *(*5)*	**66** *(*61)*

(*Revised deadline requests)

The **61** audit recommendations with proposed revised timescales for implementation can be found at ***Appendix 4***

On the basis that the Committee endorses the **61** revised timeframes, **5** audit recommendations will remain **overdue** as at **31st March 2024.** Further detail can be found at ***Appendix 5***

Table 5 below summarises the position reported as at **31st March 2024** by the Year of audit in respect of **completed** recommendations. **50** overdue recommendations have been completed in this reporting period. Further detail can be found at ***Appendix 6***

Table 5

Internal and External Audit Completed Recommendations					
Year	**Priority Rating of Recommendation**				**Total**
	Low	**Medium**	**High**	**N/A**	
2017	**-**	**-**	**2**	**-**	**2**
2020	**-**	**-**	**-**	**1**	**1**
2021	1	1	-	-	**2**
2022	3	7	2	-	**12**
2023	2	7	-	-	**9**
2024	3	12	9	-	**24**
Total	**9**	**27**	**13**	**1**	**50**



Since this reporting period 31st March 2024, recommendations with deadlines in quarter 1 of the fiscal year 2024/25 would have become overdue. These will be updated in preparation for the next reporting cycle.

For information, attached as ***Appendix 7*** is all recommendations Not Yet Due as at 31st March 2024.

Argymhelliad / Recommendation

The Audit, Risk & Assurance Committee is asked to:

- **NOTE** the position in respect of **5** overdue audit recommendations.
- **NOTE** the position in respect of **50** complete audit recommendations.
- **APPROVE** the revised timescales for the **61** Recommendations.

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

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	All terms are explained within the body of the report.



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

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




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

Agenda Item:

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	21 May 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	1. The Annual Counter Fraud Report 2023/24. 2. The Counter Fraud Work Plan 2024/25.
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Robert Holcombe, Director of Finance, Procurement and Value Based Healthcare
SWYDDOG ADRODD: **REPORTING OFFICER:**	Michelle Morris, Head of Counter Fraud

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

Er Sicrwydd/For Assurance

To provide assurance to the Audit, Risk and Assurance Committee of the work carried out by the Counter Fraud Department in 2023/24. Also to provide them with information of the work intended to be completed in the coming year 2024/25.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The attached Counter Fraud reports are:
1. The Annual Counter Fraud Report 2023/24.
2. The Counter Fraud Work Plan 2024/25.

The Annual Counter Fraud Report 2023/24 is prepared to provide assurance that the Counter Fraud Department have provided what is required by Aneurin Bevan University Health Board in order to have met its obligations under the Welsh Government Directives and the Government Counter Fraud Functional Standards SO(13).

The Counter Fraud Work Plan 2024/25 is for information to show the work planned by the Counter Fraud Department in the coming year 2024/25.

Cefndir / Background

These reports have been prepared by the Aneurin Bevan University Health Board Counter Fraud Department to comply with the Welsh legal directions and the NHS requirements of the Government Functional Standards S013.
Asesiad / Assessment Please read attached reports: 1. The Annual Counter Fraud Report 2023/24. 2. The Counter Fraud Work Plan 2024/25.
Argymhelliad / Recommendation These reports are intended for the Audit, Risk and Assurance Committee's assurance, information, and views.

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

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

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

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



ANEURIN BEVAN UNIVERSITY HEALTH BOARD

COUNTER FRAUD ANNUAL REPORT 2023/24

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1 Introduction

NHS bodies in Wales must implement anti-fraud, bribery, and corruption measures in accordance with Welsh Government Directions on Counter Fraud Measures and the service agreement under section 83 of the Government of Wales Act 2006. This report has been written in accordance with such provisions and is produced annually to demonstrate how the directions and subsequent standards for delivery are achieved.

The Directions to NHS bodies identify functions and responsibilities in relation to Counter Fraud provision and prescribe through set standards for NHS bodies as to how best achieving compliance towards these directions. The Health Board is required to comply with NHS Counter Fraud Authority's fraud, bribery, and corruption standards for providers, and produces this annual report in compliance with the direction.

The report provides detail of the work carried out by the Health Board that relates to anti-fraud, bribery, and corruption over the preceding financial year. The Welsh Government directions and standards have been developed to support NHS organisations in implementing appropriate measures to counter fraud, bribery and corruption and are presented under the following work activity areas:

- Strategic Governance
- Inform & Involve
- Prevent & Deter
- Hold to Account

The report will demonstrate and highlight the work completed under the 4 areas of activity as presented within the Government Functional Standards 013 – Counter Fraud and NHS Requirements to meet those standards is available at:

Government Functional Standard 013 Counter Fraud | NHS Counter Fraud Authority | NHSCFA

The report also references the "Self-Review Tool" (SRT) as part of the Quality Assurance process, which presents an overall RAG rating for each of the key areas of activity. The report style follows a prescribed format as recommended within the NHS Counter Fraud Authority's annual report template.

The Government Functional Standards 013 – Counter Fraud and NHS Requirements in 2021, replaced the previous, Fraud, Bribery and Corruption Standards for NHS Bodies.

Aneurin Bevan University Health Board Counter Fraud provision was resourced based on 3 FTE Local Counter Fraud Specialists (LCFS) overall:

- Michelle Morris (Head of Counter Fraud)
- Sara Morris (LCFS)

- Nicola Tillings (LCFS)

As was reported to the Audit, Risk and Assurance Committee (ARAC) throughout 2023/24 it has taken some time for the team to come to full strength. The team are also looking at reducing the need for administrative support to generate some additional resource to adequately deal with the increasing referrals- a part-time (WTE 0.64). This process started in quarter four with the assistance and support of HR but will probably not conclude until some months into 2024/25.

For ease of reference, the report follows the four key areas of action assessed through the NHS Protect Quality Assurance Framework which links to the National Counter Fraud Strategy for Wales. The report gives details of work carried out by the LCFS. The information referred to in this report contributes to the Counter Fraud strategy for the Health Board.

The Counter Fraud Work plan provides a more detailed account of the specific tasks undertaken by the Counter Fraud Officers. This work plan is used to inform the ARAC on a regular basis of progress made against the planned activity throughout the year. In the Counter Fraud Work Plan for 2023/24 it was estimated that the LCFS provision would provide 535 days but in fact for 2023/24 570 days were provided due to all LCFS staff working full-time.

As it can be seen due to the volume of investigations undertaken some days (29) were taken from Inform and Involve and utilised with the additional days to Hold to Account. This mean that a further 64 days were required in this area in the past year. This was unavoidable but necessary in the given circumstances.

Table to illustrate Resource position 2023/24

AREA OF ACTIVITY	Resource Allocated (days) 2023/24	Resource Used (days)
STRATEGIC GOVERNANCE	109	109
INFORM AND INVOLVE	149	120
PREVENT AND DETER	54	54
HOLD TO ACCOUNT	223	287
TOTAL	**535**	**570**

Cost	£

Proactive costs (Strategic Governance, Inform and Involve, Prevent and Deter)	£92,684.22
Reactive costs (Hold to Account)	£93,994.23
Total costs for counter fraud, bribery, and corruption work	**£186,678.45 ****

** These are actual costs including admin support and back payments for previous years for current employees and expenses (£173.86).

2 Management Summary

The main achievements highlighted in this report are as follows:

All key requirements of the Welsh Government Directions to NHS Bodies on Counter Fraud Measures have been achieved.

During 2023/24, the Counter Fraud Team carried over **35** active cases from the previous year, received and recorded **72** new referrals. During the year eighty (**80**) cases were closed. Twenty-Seven (**27**) cases will remain open and under review at the end of this financial year and will be carried over into the next. In this year **13** Interview Under Caution (IUC) have taken place. In relation to the cases carried over several are at the stage where an Interview Under Caution (IUC) is required, or an IUC has been undertaken and further Investigative actions have been identified. For one of these cases a file of evidence is currently being prepared for submission to the Crown Prosecution Service (CPS). There are 3 cases awaiting Police Cautions that are also subject to the internal disciplinary process.

Of those investigations that were finalised and closed in 2023/24, two members of staff received Police cautions. A further **21** civil sanctions were instigated, including the recovery of funds totalling **£220,191.66**. mainly from overpayment of salary cases. There have been **6** internal disciplinary sanctions and **2** professional body sanctions.

It is noted that the number of referrals investigated by the Counter Fraud Team has increased considerably this past year **72** cases were referred, and **80** cases have been finalised in comparison with the past years where the maximum over the past five years has

been **50**. As a result of this there has been a decrease in the number of days assigned to the area of Inform and Involve.

It is important to note that not all referrals received resulted in investigations, some of these would have been concerns or system weaknesses, which would have been reviewed and actioned accordingly.

In conjunction with the Health Board's Workforce & Organisational Development Directorate, all cases developed that were linked to a current employee were referred to the relevant workforce contact, and subsequent workforce reviews / disciplinary cases were completed following the sharing of intelligence around the Counter Fraud findings.

Additionally, as a matter of professional routine practice, where investigations involved members of professional bodies, referrals were made to each respective body, allowing them the opportunity to consider undertaking their own investigations with regards to the conduct of the specific individual involved. Such relationships and professional working practices will continue through the current working period, and continued liaison will remain for cases carried forward. There has been **2** rulings in 2023/24 where the Nursing and Midwifery Council have investigated Aneurin Bevan University Health Board staff as a result of Counter Fraud's intervention, and as a result have been struck off their professional body register.

There continues to be an issue for Counter Fraud investigating staff with medical job plans. Historically some medical staff displace their SPA and DCC administration sessions outside the usual working week, sometimes in order to facilitate private working. This has been seen recently in an investigation of working whilst sick which has highlighted how this has frustrated management action. This accepted practice must be eradicated in order to allow proper management of Job Plans in line with the usual working week, in order to prosecute those who take advantage of what is currently a weak system. It is hoped that the new online 'Job Planning System' and 'Private Working Policy' being produced by the Health Board and Medical Directors Office respectively will alleviate this issue.

Communication and awareness development have been utilised on a targeted basis throughout the year. Training was provided to areas highlighted through investigations or to high-risk staff groups. In the past year the Pan-Gwent Senior Nurse Managers, Community Dental Department, Pharmacy and Medical Directorate Administrative staff have all been provided with bespoke Fraud Awareness Training which highlighted the potential frauds within their role areas. This sits alongside the mass awareness programme which utilised mass communications to deliver the counter fraud message via face-to-face awareness events, e-newsletter, global email system, staff alerts.

In February 2024 Aneurin Bevan University Health Board made the decision to mandate the E-Learning for all staff for Fraud, Bribery and Corruption. This E-Learning also covers Declaration of Interests, Hospitality and Gifts. Further work on this topic will be undertaken in 2024/25 as part of the planned Contract Monitoring and due Diligence all-Wales LCFS exercise. Since its inception on the 20th February until 31st March 2024, 45 % of staff members (**7025**) have successfully completed it.

There has been a notable increase in the number of staff contacting the Counter Fraud Team to request advice and assistance in relation to their concerns around staff behaviour, risk, or system weaknesses. This meets the intended strategy of evolving the Team from being a contact to report 'when things go wrong', to a contact point to reach out to for mitigation advice and support.

The LCFS continue to work closely with NHS CFS Wales Regional Team to provide appropriate information and to liaise on all referrals with particular use made of the financial investigation capabilities of the Regional Team including use of Proceeds of Crime Act powers. Casework was reported on a quarterly basis for the NHS CFS Wales to monitor activity and provide Welsh Government with the Counter Fraud statistics. One such case referred to the Regional Team has resulted in a fraud recovery of **£25,008.61**.

Liaison between both internal and external auditors has been maintained, in conjunction with regular review of Audit Papers submitted by internal audit via ARAC. In addition, the Local Counter Fraud Champion and Board Secretary provides a governance link to the Counter Fraud Department, raising any concerns when appropriate.

Updates are presented and reviewed where audit reveals a potential fraud risk or system vulnerability for the Counter Fraud Team to assess. The key focus has been retained with fraud awareness and the improvement of early involvement of the Counter Fraud officers through partnership working as main priorities. In order to fully assess risks associated with Contract Management and Due Diligence, a greater emphasis and focus on collaborative working will be required throughout 2024/25.

Greater communication between the LCFS and external organisations has continued to result in improved levels of intelligence, in accordance with Data Protection and legal sharing provisions, including greater collaboration between the Police and NHS Wales Shared Services Partnership (NWSSP) functions, such as Post Payment Verification (PPV). Previously there has been difficulties with Gwent Police carrying out Police Cautions on behalf of NHS Counter Fraud. This was again highlighted in 2023 but going forward into 2024/25 this issue appears to be resolved. This was following the formal meeting between the Head of Counter Fraud and Gwent Police where assurances were made, and a proper process put in place.

Advice has also been provided for managers, patients, contractors, and staff when required, and the service is able to demonstrate that it is an asset for improving systems, as well as applying appropriate sanctions where those systems may have been abused. Policy and departmental documentation reviews have been completed as a matter of routine during all enquiries, and fraud proofing advice offered and implemented where required.

This year has seen a significant increase in the number of policies / standard operating procedures being reviewed. The Head of Counter Fraud sits on the Policy Group and therefore reviews all new and existing policies within the Health Board that come before the group for renewal to ensure that they are fraud proofed. It is encouraging to see that a Counter Fraud input is being considered as part of this routine review process and this then aligns to what is required by the Government Functional Standards.

Fraud Preventative Losses are a new type of counter fraud activity that is being driven by NHS Counter Fraud Authority. Increased capture of data is proposed in this area to attempt

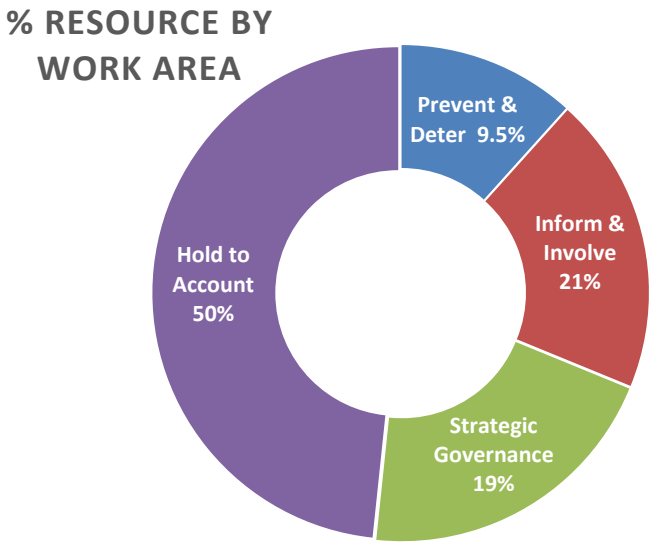
to provide insight into the impact of counter fraud work in the form of savings made (or fraud losses prevented), to highlight and measure the effectiveness of work carried out. A new standardised formula to calculate the value of pro-active work has been approved by the cabinet office and rolled out by the Counter Fraud Authority, with a view that it will be operational from Q1 2024/25.

Fraud alerts and staff alerts around Counter Fraud have been issued, including fraud and drug alerts, utilising a variety of mediums to deliver such messages. The drug fraud alerts have also been subject to review and agreed actions through a structured delivery approach, with the Head of Counter Fraud sitting on the Local Intelligence Group for the region, alongside partners both internally and externally.

Applicable sanctions have been successfully utilised by the Counter Fraud team in its dealings with alleged fraud. Evidence of criminal, civil and disciplinary sanctions can be demonstrated, ensuring that resource is put to best use. Sanctions are also essential in acting as effective deterrents.

This year has also seen the Head of Counter Fraud and Fraud Champion engage on a regular basis, enabling greater discussion of fraud concerns and collaboration between both the Counter Fraud Department and the Corporate Finance Department.

Area of Activity Overview



As per previous years, the 2023/24 work overview illustrates how a significant amount of work activity fell around the area of Hold to Account.

3 Welsh Government Direction

The following grid identifies the key requirements under Welsh Government (WG) Directions July 2006 and outlines current activity within each section. The table illustrates that, in line with WG directions, supported through compliance with the standards for Wales, Aneurin Bevan University Health Board Counter Fraud provision is illustrating positive performance in delivery of its Counter Fraud Strategy.

Para.	Instruction	Action taken by health body
2 (1)	Each NHS body must take all necessary steps to counter fraud in the NHS in accordance with these Directions and in accordance with. (a) the NHS Counter Fraud and Corruption Manual; and (b) the policy statement "Applying appropriate sanctions consistently" published by the CFS, (c) and having regard to guidance or advice issued by the CFS.	**Achieved**
2 (2)	Each NHS body must require its Chief Executive and Director of Finance to monitor and ensure compliance with these Directions.	**Achieved**
3 (1)	Each NHS body must co-operate with the CFS to enable the CFS efficiently and effectively to carry out its counter fraud functions and in particular each NHS body must, subject to the following paragraphs of this direction. (a) enable the CFS to have access to its premises. (b) put in place arrangements which will enable the CFS to have access, as appropriate, to the NHS body's staff; and (c) supply such information including files and other data (whether in electronic or manual form) as the CFS may require for the purposes of the CFS counter fraud functions.	**Achieved**

Para.	Instruction	Action taken by health body
3 (2)	In the case of information required under paragraph (1)(c) in connection with the CFS responsibility for quality inspection, fraud measurement, National Proactive Exercises (NPEs) and fraud prevention reviews, inspections and instructions, an NHS body must respond to any request from the CFS as soon as reasonably practicable.	**Achieved**
3 (3)	In the case of information required under paragraph (1)(c) for the purposes of investigations relating to the CFS' counter fraud functions, an NHS body must respond to a request as soon as reasonably practicable and in any event within seven days from the date the request was made.	**Achieved**
3 (4)	Nothing in paragraph 1(b) contravenes any right a member of staff may otherwise have to refuse to be interviewed.	**N/A**
3 (5)	Nothing in paragraph 1(c) or direction 7(f) obliges or permits an NHS body to supply information which is prohibited from disclosure by or under any enactment, rule of law or ruling of a court of competent jurisdiction or is protected by the common law.	**N/A**
3 (6)	Without prejudice to the generality of direction 2(1)(a), each NHS body must comply with the requirements specified in the NHS Counter Fraud and Corruption Manual concerning. (a) the arrangements for reporting fraud cases to the LCFS and to the NHS body's audit committee and auditors. (b) the arrangements for agreeing to undertake a criminal prosecution and to refer a matter to the police. (c) the confidentiality of information relevant to the investigation of suspected fraud. (d) the arrangements for the LCFS to report weaknesses in fraud related systems to the CFS and the NHS body's audit committee and auditors; and (e) the arrangements for gathering information to enable the Director of Finance to seek recovery of money lost through fraud.	**Achieved**
5 (1)	Each NHS body must nominate at least one person that it proposes to appoint as the body's LCFS within six weeks of the date on which these Directions come into force.	**Achieved**

Para.	Instruction	Action taken by health body
5 (2)	A person nominated under paragraph 5(1) may be either employed by the NHS body or a person whose services are supplied to it by an outside organisation.	**Achieved**
5 (3)	The name of the nominee must be notified to the CFSMS together with the information specified in the NHS Counter Fraud and Corruption Manual within 7 days of the nomination.	**Achieved**
5 (4)	Without prejudice to the generality of direction 2(1), before making a nomination each NHS body must consider any guidance issued by the CFSMS on the suitability criteria for an LCFS.	**Achieved**
5 (5)	After a nominee has. (a) been approved by the CFS as a person suitable for appointment. (b) successfully completed any training required by the CFS; and (c) been accredited by the Counter Fraud Professionals Accreditation Board, the NHS body may appoint the person as its LCFS.	**Achieved**
5 (6)	Where an NHS body nominates a person, whose services are provided to it by an outside organisation, it must: (a) comply with the requirements of the CFS as to the suitability of the organisation in question. (b) satisfy itself and the CFS that the terms on which those services are provided are such as to enable the LCFS to carry out his functions effectively and efficiently and in particular that he will be able to devote sufficient time to that NHS body; and (c) give to the CFS a copy of the contract under which the services of the LCFS are supplied to it.	**N/A**
5 (7)	A further nomination must be made within 3 months of the date on which an NHS body learns that there is to be a vacancy for an LCFS.	**Achieved**
5 (8)	The procedures in paragraphs (3) to (6) also apply to a person nominated under paragraph (7).	**Achieved**
6 (1)	Each NHS body must specify a job description for its LCFS which includes the operational and liaison responsibilities specified by the CFS.	**Achieved**

Para.	Instruction	Action taken by health body
6 (2)	The job description under paragraph (1) must include a requirement that the LCFS must adhere to the CFPAB Principles of Professional Conduct as set out in the NHS Counter Fraud and Corruption Manual.	**N/A**
6 (3)	An LCFS must report directly to the NHS body's Director of Finance.	**Achieved**
6 (4)	An LCFS must not undertake responsibility for or be in any way engaged in the management of security for any NHS body.	**Achieved**
7	Each NHS body must. (a) require that in addition to the job description mentioned in direction 6(1), the LCFS and the Director of Finance agree, at the beginning of the financial year, a written work plan which outlines the LCFS's projected work for that financial year by reference to the seven generic areas of counter fraud activity set out in the NHS Counter Fraud and Corruption Manual.	**Achieved**
	(b) enable its LCFS to attend the NHS body's audit committee meetings.	**Achieved**
	(c) require its LCFS to keep full and accurate records of any instances of fraud or suspected fraud.	**Achieved**
	(d) require its LCFS to report to the CFS any weaknesses in fraud related systems of the NHS body and any other matters which may have fraud related implications for the NHS.	**Achieved**
	(e) ensure that its LCFS has all necessary support including access to the CFS secure intranet site to enable him efficiently and effectively to carry out his responsibilities.	**Achieved**

Para.	Instruction	Action taken by health body
	(f) subject to any contractual or legal constraint, require all of its staff to co-operate with the LCFS and in particular that those responsible for human resources disclose information which arises in connection with any matters (including disciplinary matters) which may have implications in relation to the investigation, prevention, or detection of fraud.	**Achieved**
	(g) enable its LCFS to receive training recommended by the CFS.	**Achieved**
	(h) require its LCFS, its other employees and any persons whose services are provided to the NHS body in connection with counter fraud work to have regard to guidance and advice on media handling of counter fraud matters which may be issued by the CFS.	**Achieved**
	(i) enable its LCFS to participate in activities in which the CFS is engaged, including national anti-fraud measures, where he is requested to do so by the CFS.	**Achieved**
	(j) enable its LCFS to work in conditions of sufficient security and privacy to protect the confidentiality of his work.	**Achieved**
	(k) enable its LCFS generally to perform his functions effectively, efficiently, and promptly.	**Achieved**

** Please note in the above CFSMS is now the NHS Counter Fraud Authority.

4 NHS Counter Fraud Authority Quality Assurance Standards

NHS Counter Fraud Authority (NHSCFA) undertake an annual review of the counter fraud activity completed within the Health Board. The LCFS is required to complete a Self-Review Tool (SRT).

All NHS funded services are required to provide assurance against the Government Functional Standards 013 – Counter Fraud and NHS Requirements. This should be overseen by the organisation's finance director and audit committee and in line with the organisation's existing approach to assurance against counter fraud requirements.

The previous NHS specific Standards have been aligned to the new NHS CFA Requirements and the four areas of activity are:

Strategic Governance - (Organisational governance / Staff Resource / Training)

Inform and Involve – (Fraud Awareness / development of Anti- Fraud Culture)
Prevent and Deter – (Reducing opportunity / Policy review and improvement)
Hold to Account – (Detection and investigation of Fraud / Sanctions / Criminal Process)

Area of activity	RED / AMBER / GREEN
Strategic Governance	**GREEN**
Inform and Involve	**GREEN**
Prevent and Deter	**GREEN**
Hold to Account	**GREEN**
Overall level	**GREEN**

4.1 Strategic Governance

The Counter Fraud Work Plan agreed with the Director of Finance was presented to ARAC and quarterly monitoring reports submitted for information.

Meetings with Health Board Senior Managers have continued and the identification of further areas of risk from a local perspective, with the application of their professional experience within the Health Board, has been achieved.

The LCFS attended both Wales Counter Fraud Conferences, where further training was received in accordance with NHS CFA requirements.

Submission of the return for NHS Counter Fraud Authority Quality Assurance Assessment was made within the due deadline of 31st May 2023. Throughout the year quarterly returns for WG and NHS CFA in relation to investigation statistics were provided.

The necessary support has been received from the Health Board, allowing LCFS to perform their functions effectively. Continued training for specialist delivery has been maintained for all staff.

Regular contact has been maintained between the Head of Counter Fraud and Fraud Champion throughout the year, ensuring a top-down approach to developing an effective Counter Fraud Culture within the organisation.

4.2 Inform and Involve

There is an anti-fraud, bribery and corruption policy in place that outlines the responsibilities of staff in countering fraud and corruption within Aneurin Bevan University Health Board.

Bespoke virtual and face to face Counter Fraud learning has been provided to targeted staff groups, identified as higher risk of contact with fraud or there has been a fraud investigation within that area. Therefore, presentations have been delivered to Pan-Gwent Senior Nurse Managers, Community Dental Department, Pharmacy and Medical Directorate Administrative staff.

Evaluations of sessions have been conducted, with positive comments received regarding the value of receiving these awareness sessions. Evaluations and feedback have informed tailoring of learning, to ensure that bespoke guidance can be offered.

The Team has also maintained and updated its intranet pages and in 2024/25 will make the transition to digital newsletters via MS Sway. This will allow for a more interactive approach to delivering awareness, including utilising, and embedding digital material into the documents.

This year's Fraud Awareness Week was again delivered in person and each of the major hospitals were visited. During this week an estimate of **300** staff members were spoken too as well as a number of members of the public. This was coupled with daily communications via the intranet issued to both the staff and public, highlighting National Fraud Week the NHS Fraud Risks, reporting mechanisms, and making awareness materials available.

Examples of key work areas and successful outcomes include:

- Several virtual/ in-person presentations conducted to staff and key contacts. All new staff currently receive the Counter Fraud presentation video at Induction, but a request has been made by Counter Fraud to replace this with in-person or via Teams for 2024/25.
- During 2023/24 the Counter Fraud Department has undertaken **15** awareness events, which have been reported to NHS CFS Wales throughout the year.
- The Fraud Awareness Week campaign was undertaken both in person and online, resulting in the circulation of promotional literature, placement of Fraud Reporting line details within key areas.
- In order to develop and improve working relationships with our NWSSP Partners, presentations were provided to NWSSP Procurement, with a view of promoting the need

to report concerns at the outset and greater collaborative working to identify future risks / fraud trends via making better use of data analytics.

- In February 2024 Counter Fraud E-Learning was mandated for all staff. Within a short period 45% of staff completed the training which also includes information not only about the types of fraud committed within the NHS but also provides information about bribery, conflicts of interest, and hospitality and gifts. Medical and Dental and Estates have the two lowest compliance rates, as such there will be a focus on these two directorates in the coming year.

4.3 Prevent and Deter

The LCFS have effectively liaised with the Health Board's Communications Department when reporting cases or fraud trends, to ensure that a consistent approach is taken, and the message is sent out that fraud will not be tolerated within the Health Board. This resulted in the positive media coverage of a successful Fraud Case involving an overpayment of salary.

The LCFS provide reports on policy weaknesses in each case where fraud is established to both CFS Wales and relevant department within the Health Board, most recently working with Workforce and Finance to review and update the Health Board's Overpayment and Underpayment policy.

Staff alerts displayed on the Health Board website and circulated through mass communications have also encouraged engagement and demonstrated real advantages to maintaining an anti-fraud culture. There has been a significant increase throughout the year in staff seeking advice and guidance in order to reduce the risk of fraud in their respective areas of work. This represents a shift from the Counter Fraud Team being viewed as a contact point for referral of information for investigation to an asset to be utilised to prevent fraud from occurring.

The LCFS has also undertaken fraud-proofing of internal policies and procedures both during the Global Consultation of such policies but also in response to fraud risks. Additionally, it is pleasing to see that over the past year, Counter Fraud have been asked to comment of a significant amount of Finance policies and Standard Operating Procedures as a matter of procedure, as opposed to a specific risk being identified. This has resulted in the LCFS undertaking 10 policy reviews over the course of the year.

Following the recommencement of the Post Payment Verification (PPV) workplan, the LCFS has continued to monitor reports with the relevant Primary Care Lead officers. Further collaborative work is being undertaken with bi-monthly meetings at an all Wales and local level. This has resulted in the identification of Fraud Case and subsequent Civil Recovery.

The Counter Fraud Team has undertaken several Local Pro-Active Exercises (LPEs), some of which were linked to identified risks, these included:

- NWSSP– Salary Sacrifice Car Lease.
- ABUHB – Salary Sacrifice Bike Scheme.
- Bank staffing.
- All-Wales Agency Working.

The LCFS have maintained their activity with regard to the National Fraud Initiative (NFI), carrying out checks across all matched data reports, updating privacy notices and submitting data for the next data exercise. The work has also supported other Public Sector Organisations in their NFI activity. There have been several requests for information via the system which have been actioned and reported back on.

4.4 Hold to Account

The LCFS has continued to work with internal and external audit services, alongside payroll and workforce leads, to ensure that counter fraud work was carried out in accordance with the Counter Fraud Strategy.

The LCFS receives information from several sources and processes are in place to ensure referrals are prioritised and investigated. As part of the required reporting processes, all notified concerns are reported utilising the NHS CFA crime reporting system, Clue3. All current cases are logged on this system.

The new system ensures the effective and secure recording of sensitive information relation to ongoing investigation. The Clue3 system will allow for users to accurately document the types of investigations being undertaken, outcomes and systems weaknesses at an all-Wales level. This will enable the NHS CFA to release more accurate benchmarking and trend analysis data in the future. In addition, the new system will allow users to record data associated with pro-active exercises undertaken at a local level, including any fraud risks identified and potential savings produced. This information will allow the NHS CFA to demonstrate a financial value associated with Pro-active work, something which has been difficult to demonstrate over the years. This benchmarking data is expected to be available in Quarter 1 of the 2024/25 financial year.

Update reports on current case positions have been supplied to the ARAC on a regular basis. The reports are discussed during the in-committee section of the meeting to ensure confidentiality of investigation and fairness to investigation subjects.

The Counter Fraud Team has actively investigated and closed 80 investigations in the 2023/24 financial year, which included 35 cases carried over from the previous year. 72 new investigations were received and commenced. This work has resulted in the application of criminal, internal and civil sanctions. The overall recovery for the Health Board in relation to fraud investigations stands at **£220,191.66.**

Of these investigations **27** will remain open and be carried forward into 2024/25 financial year for continued investigation/closure following internal/external disciplinary.

Through the investigative work carried out this year a closer working relationship has been achieved with HR and Senior Management within Facilities. Whereby Facilities Senior Management have reported directly to Counter Fraud on a number of issues that have come to light and working together has achieved a better outcome.

5 Conclusion

The Health Board's Counter Fraud provision has demonstrated compliance with the requirements of the Welsh Government Directions to NHS Bodies on Counter Fraud Measures.

The overall Green rating from the Quality Assurance assessment (SRT), demonstrates the continued efforts from the LCFS in working in an innovative way to achieve a balance of both reactive and proactive work to meet the NHS Counter Authority's Standards.

The Counter Fraud Team can demonstrate a continued trajectory of improvement across the service, with continued success shown across key measurable. Key areas of work for next year will be to maintain focus on inform and involve, continuing to raise awareness of Fraud, Bribery and Corruption and further embedding a counter fraud culture fostered over preceding years as well as further developing work associated with Prevent and Deter, including building on Fraud Risk Analysis, identifying specific Fraud Risk based proactive exercises and recording outcomes on Clue3 against the Government Functional Standards 013 – Counter Fraud and NHS Requirements.

The Health Board's counter fraud provision has demonstrated compliance with the requirements of the Welsh Government Directions to NHS Bodies on Counter Fraud Measures.

Michelle Morris
Head of Counter Fraud, Aneurin Bevan University Health Board
For presentation to Audit and Risk Assurance Committee: 21st May 2024.

Appendix - Case and Sanction Information Overview

Case Information	Number
Cases carried forward from previous year	35
Cases opened during period	72
Cases closed in period	80
Cases ongoing	27

Sanction Imposed	Number
Disciplinary referrals	6
Civil	21
Criminal	2



Counter Fraud Work Plan 2024/25

Michelle Morris
Head of Counter Fraud Services

24th April 2024

Introduction

The Aneurin Bevan UHB Counter Fraud Team currently consists of the Head of Counter Fraud and 2 full-time Local Counter Fraud Specialists (LCFS), all three are Accredited, experienced investigators, whose primary role is to operationally deliver the obligations for countering fraud, bribery, and corruption, within a WTE resource of 210 days per year (630 days total). In the 2023/24 Work Plan a total of 535 days were allocated due to the fact that the previous year one of the LCFS worked part-time.

It is hoped that the investigative resources in the team may increase during this current financial year with the re-structuring of the department, whereby the team will forego its administrative support officer, once the displaced staff member has been redeployed, a recruitment exercise will take place for an additional part-time LCFS (0.64 WTE). This would add to the total of 630 days above.

The Counter Fraud Team works closely with the Director of Finance, Procurement and Value Based Health Care, the Fraud Champion (Assistant Director of Finance), and reports regularly to the Audit & Risk Assurance Committee on fraud, bribery, and corruption matters.

Following introduction of new Government Functional Standards on Counter Fraud, which replaced NHS Counter Fraud Authority's (NHS CFA) 'NHS Counter Fraud Standards (Wales)' from 2021/22, the Health Board's Counter Fraud Workplans have been aimed at ensuring compliance with these new standards.

This Work Plan is set around proactive activity covering Strategic Governance, Inform & Involve, Prevent & Deter and as well as reactive activity covered by Hold to Account. The planned days are split as proactive days – **365 days** and reactive days – **265 days**.

The guidance previously provided by NHSCFA in relation to the recommended allocation of work days based on the size of the NHS organisation is as follows:

Number of staff	Number of Pro-Active Counter Fraud days
Less than 4,999	295
5,000 to 9,999	305
10,000 to 13,999	315
More than 14,000	325

COUNTER FRAUD WORK PLAN 2024/25

Following a review and the experience of the current year, the additional 95 days available have been allocated between Inform and Involve (27), Prevent and Deter (26) and Hold to Account (42). The number of days for Strategic Governance has remained the same as last year.

Hopefully the number of these days may increase if there is an appointment of the additional part-time LCFS within this financial year. This also has to be flexible with the needs and requirements of the Health Board; allowing for the fact that due to the number of referrals in 2023/24 more resource time was dedicated to investigative duties.

In line with the Welsh Government Directions on Counter Fraud Measures, the counter fraud work undertaken by the Counter Fraud is set around four key principles:

Key Principle 1: Strategic Governance - to ensure that Strategic Governance arrangements are in place to ensure that Anti-Crime measures are embedded at all levels across the organisation. Good communication with Senior Staff within key staff areas as well as regular attendance and oversight from the Audit & Risk Assurance Committee will continue.

Key Principle 2: Inform and Involve – to raise awareness of fraud risks against the Health Board with the overall aim to have a workforce that is fraud aware, vigilant, and intolerant of fraud bribery and corruption in the NHS. Effective use of multi-media channels in order to reach staff across the Health Board will be vital to effective delivery of this principle.

Key Principle 3: Prevent and Deter – to utilise all available means to identify and mitigate anomalies indicative of fraud and to produce a 'fraud-proofed' environment to discourage individuals who may be tempted to commit fraud against the NHS and ensure that opportunities for fraud to occur are minimised.

Key Principle 4: Hold to Account - to ensure that all suspicions of fraud are investigated in a timely, professional manner and that all appropriate sanctions and redress actions are applied to send the message that fraud against the Health Board will not be tolerated. ***Also to make those responsible pay back the losses in order that this money can be placed back into patient care.***

NHS bodies in Wales must implement anti-fraud, bribery, and corruption measures in accordance with Welsh Government Directions on Counter Fraud Measures and the service agreement under section 83 of the Government of Wales Act 2006. As well as the WG directions, NHS bodies are also obliged to demonstrate compliance with the Government Functional Standards 013 - Counter Fraud (GovS 013), which came into effect from 1st April 2021. A self-review assessment against each of these 12 standards is completed on an annual basis using a RAG rating system.

COUNTER FRAUD WORK PLAN 2024/25

The Government Functional Standards and NHS Requirements to meet those standards are available in full at https://cfa.nhs.uk/government-functional-standard/NHS-requirements.

COUNTER FRAUD WORK PLAN 2024/25

STRATEGIC GOVERNANCE		
	TASK/OBJECTIVE	**PROPOSED DELIVERY**
1	Attendance at all Fraud Forum meetings held by NHS CFS Wales.	As Required
2	To ensure that there is always a nominated Fraud Champion for the Health Board in line with GovS 013 component 1. A new Fraud Champion will need to be nominated upon the retirement of the Assistant Director of Finance.	Q3/Q4
3	Completion and agreement of the annual work plan with Director of Finance in line with GovS 013 component 2.	Q4
4	Completion and agreement of the annual report with Director of Finance.	Q1
5	Regular meetings/liaison with Director and/or Assistant Director of Finance.	Throughout the Year
6	Preparation for and attendance at ARAC meetings.	As Required
7	Full participation in the quality assurance process as directed by NHS CFA.	Q4 and As Required
8	Undertake additional training as required by the Health Board or NHS CFA.	As Required
9	Continuing use of CLUE 3 case management system, as mandated by the NHS CFA. Utilise this system to record all fraud, bribery, and corruption investigative activity, including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercise in line with GovS 013 component 8.	Throughout the Year
10	Provide regular reports and *ad hoc* information to NHS CFA and Welsh Government as required	Throughout the Year
11	Review the Health Board's Counter Fraud Policy and Response Plan to ensure up to date and relevant contents as well as alignment to Government Functional Standards in line with GovS 013 component 4 and GovS 013 component 7.	As Required
12	To continue with attendance at ABUHB's monthly Policy Working Group in order to review all current policies that are presented in order that they are fraud proofed going forward.	Throughout the Year.

COUNTER FRAUD WORK PLAN 2024/25

STRATEGIC GOVERNANCE		
	TASK/OBJECTIVE	**PROPOSED DELIVERY**
	TOTAL DAYS ALLOCATED	**109**

INFORM AND INVOLVE		
	TASK/OBJECTIVE	**PROPOSED DELIVERY**
13	Design and deliver a programme of counter fraud awareness presentations to staff at all levels within the Health Board, including participation in the Health Board induction programme, with the aim of ensuring that the organisation is proactive in raising fraud awareness and building an anti-fraud culture in line with GovS 013 component 11. Review and maintain materials and media used. Aim to provide as many in-person presentations as possible. Evaluate presentations, collate results, and amend presentations as a result of the target audience/ feedback received. Report outcomes to the Director of Finance.	Throughout the Year
14	Undertake awareness work to highlight the availability of counter fraud awareness training aiming to increase attendance numbers.	Throughout the Year
15	To develop and maintain the counter fraud information contained on the Health Board's intranet site, to include details of successfully prosecuted cases – both local and national.	Q2 and Q4
16	Ensure that Fraud and Corruption Reporting Line advertising posters are displayed throughout the organisation, publicising the free-phone reporting line number.	Throughout the Year

COUNTER FRAUD WORK PLAN 2024/25

INFORM AND INVOLVE		
	TASK/OBJECTIVE	**PROPOSED DELIVERY**
17	Actively promote and encourage staff awareness and completion of the mandatory Counter Fraud E-learning package.	Throughout the Year
18	Arrange for pay-slip messages to be utilised during the year as appropriate.	As Appropriate
19	Develop a digital Counter Fraud newsletter that can be incorporated into the general communication briefings that are currently being circulated amongst staff via the communications department, which will allow for greater awareness throughout the year.	Throughout the Year
20	In conjunction with the Health Board Communications Team, review the strategy in place for raising awareness of economic crime risks and publicise the work of the LCFS, to ensure that it remains fit for purpose and that all appropriate awareness-raising mechanisms are being fully exploited.	Q1/Q2
21	In line with GovS 013 Components 4, 7 and 12 undertake targeted surveys of staff to measure awareness of: Counter Fraud, Bribery and Corruption Policy and Response Plan. Fraud, Bribery and Corruption incident reporting routes; and Policy and procedures relating to Conflicts of Interests, Gifts and Hospitality and Bribery Act.	Throughout the Year
22	Utilise the finding and results of the fraud risk assessment programme to inform delivery of counter fraud training to business areas of higher risk of exposure to fraud. This was started in 23/24 and will continue throughout this coming year.	Throughout the Year
	TOTAL DAYS ALLOCATED	**176**

COUNTER FRAUD WORK PLAN 2024/25

PREVENT AND DETER		
	TASK/OBJECTIVE	**PROPOSED DELIVERY**
23	Review key organisational policies, procedures, and documents, to ensure that they are adequately robust to counter fraud. The communication of revised policies, procedures, and documents as appropriate, emphasising the organisational commitment to countering fraud. This will require attendance at Policy Group Meetings.	Monthly
24	Carry out risk analysis in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology. Record and manage assessed risk in line with the Health Board's Risk Management policy and include on the risk registers where appropriate in line with GovS 013 component 3.	Throughout the Year
25	Utilise DATIX for recording of risk assessment work to effectively manage, evaluate, evidence and measure the effectiveness of counter fraud work in mitigating and reducing fraud risk or expenditure and influencing of policy and procedure aimed at reducing fraud in line with GovS 013 component 2, GovS 013 component 3 and GovS 013 component 5.	Throughout the Year
26	Liaise with Corporate Governance colleagues around measuring effectiveness and staff awareness of conflicts of interest policy and registers that include gifts and hospitality with reference to fraud, bribery and corruption, and the requirements of the Bribery Act 2010 in line with GovS 013 component 12.	Q3/Q4
27	Review and update information sharing protocols currently in place. Review and refresh protocols with key partners of Internal Audit and Workforce & Organisational Development	Q4
28	Regular meetings with the Head of Internal Audit (NWSSP Audit & Assurance)	Throughout the Year
29	Record and respond to ad-hoc requests for assistance received.	Throughout the Year
30	Action the relevant Fraud Prevention Notices issued by NHS Counter Fraud Authority and/or Counter Fraud Services Wales as and where appropriate.	As Appropriate

COUNTER FRAUD WORK PLAN 2024/25

PREVENT AND DETER		
	TASK/OBJECTIVE	**PROPOSED DELIVERY**
31	Issue of fraud alerts to all appropriate staff.	As Appropriate
32	Regular liaison with the Post Payment Verification Location Manager (NWSSP Primary Care) and Primary Care leads to ensure that any contractor visits which result in the identification of anomalies are reported to the LCFS. To attend all PPV joint Fraud meetings.	Throughout the Year
33	Participate in mandatory national proactive exercises, as instructed by NHS Counter Fraud Authority, Auditor General for Wales and/or the Cabinet Office (e.g. NFI).	Throughout the Year
34	Participate in thematic fraud risk evaluation exercises as instructed by the NHS Counter Fraud Authority. This year's thematic exercise is on Procurement. Specifically looking at new contracts in 2023/24.	Q1/Q2
35	Conduct proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery, and corruption. Results of this work will be recorded on Clue3, evaluated and where appropriate feed into improvements to prevent and deter fraud, bribery, and corruption in line with GovS 013 component 10. Any losses, recoveries or savings are to be identified and reported (data metrics).	Throughout the Year
36	Membership of Local Intelligence Network (CD LIN) and attendance at quarterly meetings.	Quarterly
	TOTAL DAYS ALLOCATED	**80**

COUNTER FRAUD WORK PLAN 2024/25

HOLD TO ACCOUNT		
	TASK/OBJECTIVE	**PROPOSED DELIVERY**
37	Conduct investigations into all allegations of economic crime as required, in line with the requirements of the NHS Counter Fraud Authority Counter Fraud Manual, and all relevant guidance and legislation.	Reactive/As Required
38	Appropriate use of the prescribed case management system Clue 3, in line with NHS Counter Fraud Authority and NHS CFS Wales requirements.	Reactive/As Required
39	Assist NHS Counter Fraud Authority and/or NHS CFS Wales as required in respect of any regional or national investigations.	Reactive/As Required
40	Ensure the application of sanctions in line with legislation and the policy document 'Applying Appropriate Sanctions Consistently'.	Reactive/As Required
41	Identify and maintain appropriate records and, wherever possible, seek financial redress/recovery in respect of any proven loss to the Health Board, having due regard to the particular circumstances of each case.	Reactive/As Required
42	Review professional competencies and capabilities of accredited staff nominated to undertake the full range of counter fraud work to assess requirements for professional development opportunities in line with GovS 013 Component 9.	Q1
43	Explore whether a Memorandum of Understanding between Gwent Police and the Health Board to cover matters of joint interest when undertaking fraud investigations is required. This will be ongoing once the initial agreement has been reached.	Q1/Q2
	TOTAL DAYS ALLOCATED	**265**

COUNTER FRAUD WORK PLAN 2024/25

SUMMARY TOTALS			
	STRATEGIC AREA OF ACTIVITY	**RESOURCE ALLOCATED 2023/24 (in days)**	**RESOURCE ALLOCATED 2024/25 (in days)**
A	**STRATEGIC GOVERNANCE**	109	109
B	**INFORM AND INVOLVE**	149	176
C	**PREVENT AND DETER**	54	80
D	**HOLD TO ACCOUNT**	223	265
	TOTAL	**535**	**630**

Agenda Item:2.3

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	21 May 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Clinical Audit Plan 2024/25 and Annual Clinical Audit Activity Report 2023/24
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr James Calvert, Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joanne Stimpson, Clinical Audit Lead Leeanne Lewis, Assistant Director for Quality & Patient Safety

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Clinical audit is one tool available for assessing whether clinical services are safe and effective.

It is one input into our Quality Management System (QMS). Clinical audit provides assurance against compliance with clinical standards and provides an opportunity to identify and minimise risk, waste, and variation in clinical practice from guideline defined standards of care.

The results of audit are used to plan and prioritise domains of care requiring improvement with the aim of improving patient outcomes.

The Health Board's focus has been to ensure mandatory participation in the Welsh National Clinical Audit and Outcomes Review Plan.

The Health Board complies with the requirements of Welsh Government by participating in all mandatory national clinical audits. Our audit plan balances national audit priorities with directorate/division/service/ clinician priorities.

The focus of the Clinical Audit Team in the last year has been to implement the Health Board's Clinical Audit Strategy through meeting and engaging with Divisions to ensure that the structures and processes to allow effective clinical audit are in place.

This paper serves to provide a summary of Clinical Audit Activity from 2023-2024 and sets out the plan for 2024-2025.

Cefndir / Background

The National Clinical Audit and Outcome Review Plan (NCAORP) is published by Welsh Government (WG) annually.

The plan is one of the cornerstones in the drive to improve quality and safety of healthcare in Wales. It sets out in detail how findings from national clinical audit projects and outcome reviews are to be used to measure the quality and effectiveness of healthcare provided to patients and to assess year on year improvements.

The plan details the full list of national audit projects that all healthcare organisations must fully participate in, where those services are provided. The Health Board's audit plan is based on NCAORP.

Following an Internal Audit report and recommendations in November 2022, the focus for the Clinical Audit Team has been to implement the Health Board's Clinical Audit Strategy. There has been engagement with Divisions and work undertaken on making the clinical audit process more effective.

Work has included:

- Producing standardised audit reporting templates, which has enabled more consistent reporting and improved scrutiny of action plans.
- Review of the ToR of the Clinical Effectiveness Committee (where audit outcomes are reviewed)
- Implementation of the web-based Audit Management and Tracking system (AMaT) has helped facilitate tracking of audit results and the development of action plans.

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

There is a robust structure underpinning the reporting of Clinical Audit, with Executive Leadership delegated to the Medical Director. Assurance is provided

through reporting to the Patient Quality and Safety Outcomes Committee (PQSOC) which provides scrutiny of National Clinical Audit performance and monitoring of improvement plans.

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

Asesiad / Assessment

The updated Clinical Audit Plan for 2024/25 and Clinical Activity Report for 2023/24 is now available. The Health Board's Annual Clinical Audit Plan and Clinical Audit Activity report is to be ratified by Patient Quality and Safety Outcomes Committee (PQSOC) in April. The activity report summarises all the audits presented at CSEG for the last twelve months between April 2023 – March 2024.

There is now a well-defined process for the scrutiny of National Clinical Audit Reports, which utilises completion of standardised audit reporting templates in AMaT to clearly delineate examples of good practice, practice that needs improvement and SMART action plans required to address these areas.

Audit reports are then presented to the Clinical Standards and Effectiveness Group (CSEG) following publication. Clinical Lead(s) for the service(s) are informed of the report due date on publication. The Quality and Patient Safety (QPS) clinical audit team registers the audit in the Clinical Audit Area via the web-based Audit Management and Tracking system (AMaT). The relevant documentation is provided to Clinical Leads, who provide CSEG with an analysis of local performance benchmarked against national recommendations. They then provide a "SMART" improvement plan for the Health Board which is available in AMaT so completion deadlines can be tracked.

The nine-month publication schedule for the NCACORP – covering the National Clinical Audit (NCA) programme and also the Clinical Outcome Review Programmes (CORP) has been shared with Directorates. The dates align with presentation of results at Clinical Standards and Effective Group (CSEG). The annual audit plan will continue to ensure mandatory participation in all national clinical audits and national confidential enquiries, including participation in audits on the National Clinical Audit and Patient Outcomes Programme (NCAPOP).

AMaT is also utilised to record compliance with NICE guidance and HTW adoption, which can then be used to identify areas for future clinical audits.

Once National Clinical Audits (NCA) are published on the Healthcare Quality Improvement Partnership (HQIP) webpage, they form part of our annual audit plan. We are currently reviewing participation in these audits and ensuring these are discussed at CSEG. If these are discussed at other Groups or Boards (e.g. Stroke, End of Life Care Board) we will reach out for assurance on completion of key results, audit actions and improvement plans. We will be requesting for these to be reported

to CSEG and placed on AMaT to align with the reporting of all other audits in the future.

Audit Management and Tracking (AMaT) is also being widely used across the Health Board for conducting and reporting on local audits agreed in the audit plan. The volume of audits being undertaken and the number of action plans being recorded is rising.

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

The audit team will continue to work collaboratively with Divisions, clinicians, service managers, divisional governance and quality managers as well as clinical staff to ensure that the clinical audit programme for their directorate meets all clinical, statutory, regulatory, commissioning and other Health Board requirements.

Ongoing training in the use of AMaT will ensure healthcare professionals are enabled to participate in clinical audit in order to satisfy the demands of their relevant professional bodies (for example, for revalidation and professional development).

The clinical audit team are developing organisational and governance structures within AMaT to support full engagement in audits. This includes 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 next audit activity report by the clinical audit team will review how learning from clinical audit can be fed back to clinical areas and that audit results are triangulated with other sources of information on the quality of clinical services as part of our QMS.

Argymhelliad / Recommendation

Agree to the Clinical Audit Plan for 2024-2025 and receive assurance from the Audit Activity Report for 2023-2024 that the Health Board is meeting its obligation to undertake clinical audit.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	

Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety 2.6 Medicines Management 2.9 Medical Devices, Equipment and Diagnostic Systems 3.1 Safe and Clinically Effective Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults Adults in Gwent live well healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	NA – National Average CA – Case Ascertainment
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Clinical Standards and Effectiveness Group

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

• **Service Activity & Performance**	Yes, outlined within the paper
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Involvement - The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves Choose an item.

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

CLINCIAL AUDIT ACTIVITY REPORT 2023/2024



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Introduction

Welcome to the Aneurin Bevan University Health Board Clinical Audit Activity Report 2023/2024. Clinical Audit is one element of a Quality Management System that helps us to understand how well we deliver care measured against published standards.

Reflections on Clinical Audit Across the Health Board

Following the Internal Audit report on Clinical Audit in November 2022, there has been increased engagement with Divisional Management Teams to focus on the implementation of the Health Boards Clinical Audit Strategy.

The Health Board's strategic focus on National Clinical Audit has been to ensure mandatory participation in the Welsh National Clinical Audit and Outcomes Review Plan (NCAORP). The Quality and Patient Safety (QPS) audit team have worked with clinical leads to ensure results of all National Clinical Audits are discussed at the Clinical Standards and Effectiveness Group (CSEG). Some National audits are also discussed at Boards and Committees throughout the Health Board (e.g. stoke, falls).

Reflections on Clinical Audit Across the Health Board Continued…….

With the introduction of AMaT (Audit Management and Tracking system) in June 2022 there has been a focus on training staff to utilise the system. Currently there are more than 1,300 users across the Health Board. AMaT is used to build the audit proforma, capture data and produce results with an action plan. This license has been extended for a further two years.

There has been improved engagement with Clinical Leads throughout the audit process to discuss results. This has enabled the development, monitoring and completion of improve (SMART) action plans. These are discussed at the Clinical Standards and Effectiveness Group (CSEG). Actions are logged on AMaT and actions are tracked by progress and date.

A standardised Clinical Audit Activity reporting template has been developed in AMaT. This supports review of audit results by CSEG and is used for onward ratification at the Patient Quality and Safety Outcomes Committee (PQSOC). The template ensures risks are discussed and can be escalated to PQSOC, once they have been raised within the Division and placed on the risk register.

Divisional teams have been asked to identify clinical audits as part of their local audit plans. This allows scrutiny and assurance of issues arising from quality and safety risks identified from Datix, complaints and outcomes of care.

Future audit work will include reviewing how the learning from audit is triangulated. This will include working with the Value-Based Health Care team and consider how patient experience is being captured and how this can be linked to audit results.

Our EFFECTIVE Commitments 2023-2026

This report will cover the National Clinical Audits (NCAs) the Health Board participated in for the period April 2023 to March 2024.

Results of clinical audit forms part of our wider Quality Management System in development in the Health Board since Implementation of the Duty of Quality in April 2023.

Audit outputs and activity contribute to the "effectiveness" domain of the Duty of Quality.

To deliver care that is effective, reliable, and based upon the best evidence available. To increase the proportion of patients who receive evidence-based care. To reduce variations in the quality of care. To identify and implement evidence-based best practice guidance. Deliver consistently effective and reliable care.

Aim	Objective
Provide effective care.	▪ Deliver consistently effective and reliable care, based on best practice which is delivered as part of a culture that encourages and enables innovation to Improve outcomes. ▪ To ensure that the care delivered to patients is effective and based upon the best evidence available. ▪ Support Divisions to drive improvement priorities from learning.
Implement the mandatory National Audit Programme.	▪ Participate in the relevant national audits to provide assurance of effective care delivery. Use the findings from the relevant national audits to support the continued improvement of quality outcomes by sharing learning and good practice across the organisation. ▪ Produce action plans to monitor the actions needed from audits, ensuring these are measurable and achievable.
Building audit capability across the organisation through skills development.	▪ Developing an organisational training offer covering all staff groups. ▪ Build audit capability across the organisation through the implementation of the web-based Audit Management and Tracking System (AMaT). ▪ Utilise Clinical Audit expertise to provide the evidence-base and measurement function which drives quality improvement initiatives.
To increase engagement with audit and effectiveness work.	▪ To improve the visibility of Clinical Audit Results by implementing the Clinical Audit Strategy, inclusing developing an internal registry ▪ Develop and embed GIRFT processes within the central team, supporting the Divisions to drive improvement priorities from learning.
Implement NICE Guidance and adoption of Health Technology Wales guidance.	▪ Ensure the relevant NICE (National Institute for Health and Care Excellence), and specialist national guidance are regularly assessed and implemented to deliver interventions based upon the best possible evidence. ▪ Utilise best practice evidence and benchmark data to improve outcomes.

Safe	Our aim is to: • Ensure that our healthcare system is high quality, highly reliable and safe and that we avoid preventable harm to patients; maximising the things that go right and learning from when things go wrong to prevent them occurring again. • People's health, safety and welfare are actively promoted and protected; risks are identified and monitored and where possible, risks to safety are reduced or prevented. • We promote and protect the wellbeing, and safety of children and adults who become vulnerable or at risk at any time. • Where children or adults may be experiencing or are at risk of abuse or neglect, we take appropriate, timely action and report concerns.
Timely	Our healthcare system ensures people have access to the high-quality advice, guidance and care they need quickly and in the right place, first time. We care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority.
Effective	Our healthcare system ensures decision-making, care and treatment reflects evidence-based best practice, to ensure that people receive the right care to achieve the optimal and possible outcomes that matter to them. We design transformative, evidenced-based, whole-of-life pathways that cover prevention, care and treatment, rehabilitation and embed these into local service delivery.
Efficient	Our health care system takes a Value-Based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We make the most effective use of resources to achieve best value in an efficient way. We only do what is needed and undertake treatments that ensure any interventions represent the best value that will improve outcomes for people.
Equitable	Our healthcare system provides everyone with an equal opportunity to attain their full potential for a healthy life which does not vary in quality by organisation providing care, location where care is delivered or personal characteristics (such as age, gender, sexual orientation, race, language preference, disability, religion or beliefs, socio-economic status, political affiliation). We embed equality and human rights in our health care system.
Person-centred	Our health care system meets people's needs and ensures that their preferences, needs and values guide decision-making that is made in partnership between individuals and the workforce. We care about the well-being of individuals, their families, carers and our staff. We ensure that everyone is always treated with kindness, empathy and compassion and we respect their privacy, dignity and human rights. We are committed to working better together to put people and their families at the centre of decisions, seeing them as experts working alongside professionals to get the best outcome and experience.



What is Clinical Audit?

Clinical Audit forms part of the system for improving standards of clinical practice. Topics for clinical audit should reflect national and/or local priorities or areas of concern e.g. Cancer Services or National Service Frameworks, or local priorities identified through incident reporting or introduction of best practice into local services. Clinical audit takes place as part of a quality improvement cycle that measures the concordance of care delivery with agreed local or national guideline defined standards. Following an audit, areas for improvement are identified and implemented before being re-audited with the aim of improving reliability and outcomes of care.

- High quality, safe care for patients using our services.
- Cost-effective clinical services to ensure that care is both sustainable and effective
- National Audit engagement at a local level.
- Compliance with regulatory requirements from NHS Wales Health and Social Services and Public Health Wales.
- Reports on the compliance with clinical standards that can be used for assurance.
- Quality improvement projects and local audits that are aligned to the Health Boards priorities for improving care.
- Demonstrable NICE compliance and best practice evidence implementation.

The Health Board (HB) is responsible for demonstrating through Clinical Audit that:

- Patients receive the best and most appropriate standards of care according to the best available evidence.
- Clinical teams can identify opportunities for changes in practice to improve the quality of patient care.
- Processes are tested to ensure they are working effectively to improve patient outcomes, experience, safety and quality of care.
- Appropriate re-audits are undertaken to ensure changes are sustained and have made improvements to the quality of patient care.
- The HB outcomes are above the National average by participating in National Clinical Audits within the National Clinical Audit & Patient Outcomes Programme (NCAPOP) and make National Clinical Audit data available in accordance with HQIP guidance.
- The HB can demonstrate to stakeholders that clinical audits are being appropriately managed and actioned in line with the NHS standard Acute Services Quality Contract and are available for scrutiny by Public Health Wales (PHW) and other external agencies.

The National Clinical Audit and Patient Outcomes Programme (NCAPOP)

- NCAPOP audits are commissioned and managed on behalf of NHS Wales by the Healthcare Quality Improvement Partnership (HQIP). The programme comprises more than 30 national audits related to some of the most commonly-occurring conditions.
- These collect and analyse data supplied by local clinicians to provide a national picture of care standards for that specific condition. On a local level, NCAPOP audits provide local trusts with individual benchmarked reports on their compliance and performance, feeding back comparative findings to help participants identify necessary improvements for patients. Most of these projects involve services in England and Wales; some also include services from Scotland and Northern Ireland.
- As well as the 30-plus national clinical audits, NCAPOP also encompasses the four Clinical Outcome Review Programmes (CORP). These help assess the quality of healthcare and stimulate improvement by enabling clinicians, managers and policy makers to learn from adverse events and other relevant data.

What is our Clinical Audit Strategy?

The Health Board has a Clinical Audit Strategy which sets out the vision for clinical audit for the Health Board. The vision is to be recognised as the best healthcare provider in our class, consistently performing within the top 10% nationally. The mission is to safeguard the health and well-being of the population we serve and to abide by our Health Board values.

The values we aim to show are:

People First

Personal Responsibility

Passion for Improvement

Pride in What We Do

The Health Board Audit Strategy has Four Priorities:

- ❖ Scrutiny of National Clinical Audit performance with robust development, monitoring, and progression of improvement plans
- ❖ Divisions to identify clinical audits that allow scrutiny and assurance associated with quality and safety risk
- ❖ Trainees are supported to participate in meaningful clinical audits that support clinical governance
- ❖ Groups and committees across the Health Board will commission clinical audit to support effective assurance where no other evidence is available.

Clinical Audit and AMaT – Audit Management and Tracking

AMaT is an innovative system designed to make auditing easier, faster, and more effective. Data can be input and accessed in real time on a smartphone, tablet, laptop or desktop computer, giving healthcare staff increased flexibility and mobility - and more time to spend with patients.

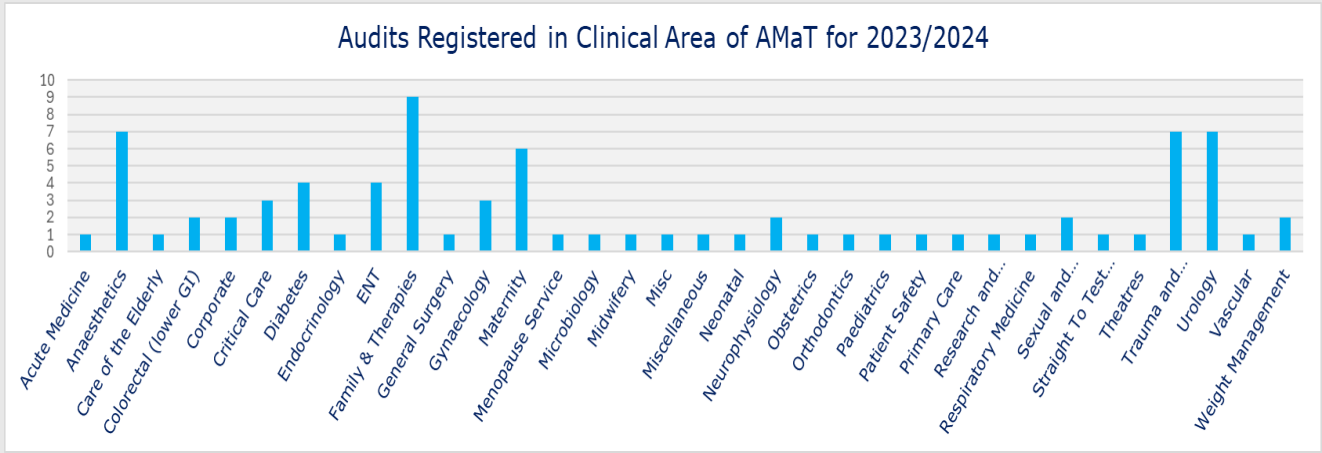
During 2023/2024, 80 projects were added to AMaT.

Project Type	Count
Clinical Audit Project	45
Other	1
Patient Questionnaire (feedback, satisfaction, etc.)	3
Quality Improvement Project	21
Service Evaluation	9
Staff Questionnaire (feedback, satisfaction, etc.)	1
Total	80

National Audits do not capture data within AMaT, however the audit process is managed in the system, using various section:

- Audit results and criteria
- Guidance (NICE, HTW, HIW, AWMSG)
- Conclusions and assurance (inc Risk)
- Key success and key concerns
- Recommendations
- Action plans

Projects were recorded under many specialties, and this will grow as the Health Board expands its use of AMaT. Recommendations can be documented, and actions given with timelines.



The Health Board action status within the clinical area shows:

Action Status	Count
Fully Complete	17
New	27
Overdue	3
Partially complete	1
Partially complete (Overdue)	1
Total	**49**

It is difficult to give a forward plan of projects within the Clinical Area as these usually are registered at the time of commencing the audit, even if this a retrospective audit.

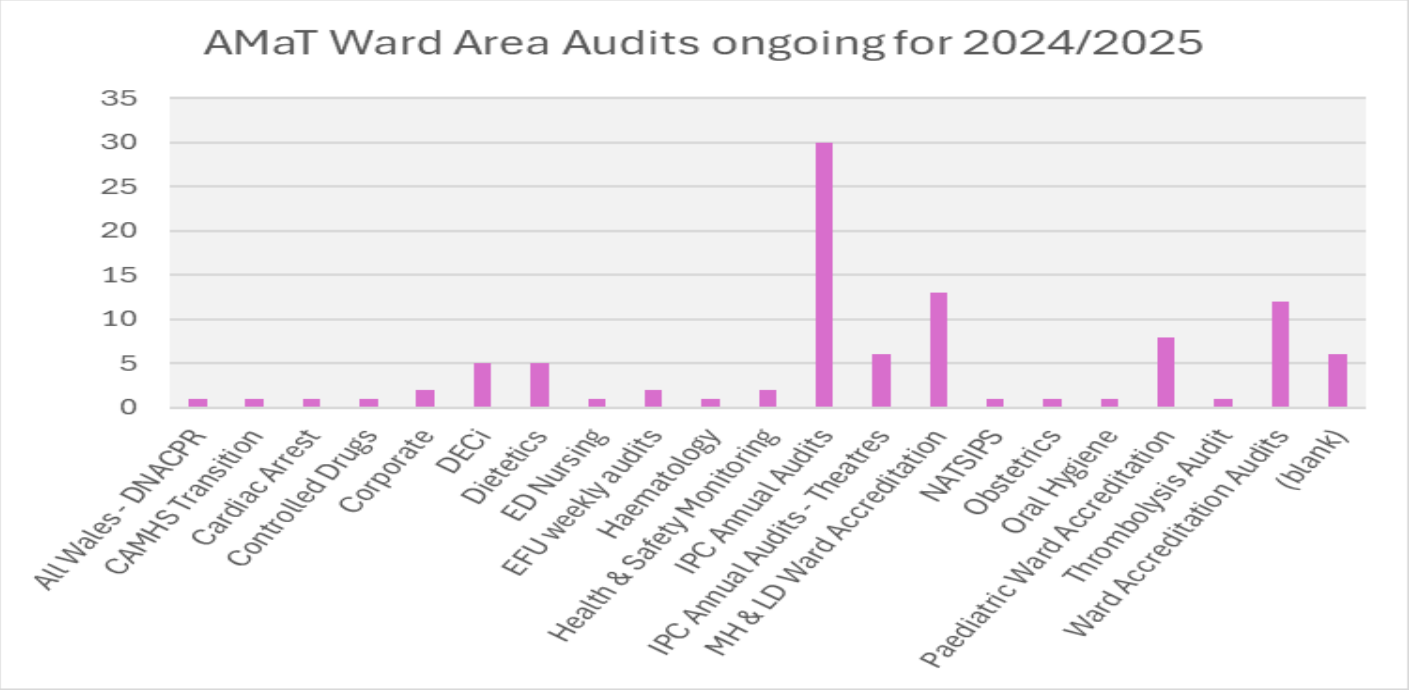
Ward Area Audits in AMaT

Ward Area is the area in AMaT which will display all audits being undertaken at ward/theatre level. These can be set within projects and the results can be viewed in the dashboard area. Action can be allocated and audited within each audit.

There are a total of 101 audits currently registered and active in Ward Area. An audit can be linked to one ward, 10 wards or all wards across the sites/Health Board.
These have generated 2,318 actions with 1,335 being fully completed to date.

Of the 101 audits registered a number are still active and included in the plan for 2024/2025. Action status for completed 2023/2024 audits are:

Action Status	Count
Action no longer relevant	24
Fully Complete	1335
New	284
Overdue	608
Partially complete	12
Partially complete (Overdue)	41
Unable to Complete	14
Total	**2318**



AMaT
Audit Management and Tracking

Risk and Governance

The Health Board will develop an organisational structure to ensure everything we do is quality-driven.
The Health Board will empower local leaders and managers to ensure patient experiences of our service is delivered locally with excellence. This requires continuous monitoring, action and delivery of quality improvements.

This will aid in strengthening Health Board governance structures through Board-to-Floor reporting that promotes cross Divisional and multi-professional working.
Clinical Leads provide assurance through the Clinical Standards and Effectiveness Group (CSEG) which reports to the Patient Quality and Safety Operational Committee (PQSOC).

The Health Boards Audit Clinical Leads will use the following Assurance and Risk levels against services delivered and can demonstrate if any area audited has been placed on a Health Board Risk Register:



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

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

What we did well in 2023/2024……



Lung Cancer – Excellent patient support from Clinical Nurse Specialists

Diabetes – Increased insulin pump therapy coverage

Myocardial Ischemia – Increased referral for rehabilitation

Early Inflammatory Arthritis – Increased referral within 3 days

Paediatric Diabetes – Successful family engagement sessions

Bowel Cancer – Quality assured rectal Cancer resections

Percutaneous Coronary Interventions – Improved same day discharge

Fracture Liaison Service – More falls assessment being carried out

Pregnancy in Diabetes – Earlier contact for women with Type 1 diabetes

ALL SUCCESSES CAN BE SEEN IN THE NATIOANAL AUDIT REVIEWS IN THE APPENDICES

Vascular Services – Overall good clinical outcomes for patients

Diabetes in Primary Care – increase in obtaining Care Process and Treatment Targets since the pandemic

Neonatal care – Increased Neonatal staffing in line with national standards

Prostate Cancer– Same day discharge for robotic prostatectomies

Heart Failure – Improved medication reviews and reduced 30-day re-admission rates

We have standardised the reporting template to ensure continuity between audits

We have formed relationships with Clinical Leads to improve participation and promote confidence in audit

We have supported Clinical Leads to design audit

We have implemented AMaT and trained over 600 staff

Did we achieve our goals for 2023/24

✓ Fully implement the Clinical Audit Strategy throughout the organisation.	Achieved
✓ Implement the Internal Audit recommendations and action plan.	Achieved
✓ Continue to ensure mandatory participation in National Clinical Audit and Patient Outcomes Programme (NCAPOP) commissioned by Healthcare Quality Improvement Partnership (HQIP) & NHS Wales National Clinical Audit Outcome Review Plan (NCAOPR) and engagement at a local level.	Achieved
➢ Develop local audit plan with Divisions.	Ongoing
➢ Continue to fully embed AMaT; working on governance structure.	Ongoing
✓ Secured future funding stream for AMaT	Achieved
✓ In line with the Duty of Quality ensure the Health Boards delivers on its commitment to quality and effectiveness through the application of clinical audit to support delivery of: High quality care, patient safety, patient experience and clinical effectiveness.	Achieved
➢ Ensure actions and findings from national and local clinical audits are monitored at an appropriate forum and should be utilised to inform future planning within the Health Board.	Ongoing
➢ As part of Quality Planning, ensure that national clinical audits inform the Health Board's future planning and forms part of the Health Board's and Divisional Integrated Medium-Term Plan (IMTP).	Ongoing
➢ Triangulate the learning from clinical audits to improve services.	Ongoing
➢ Complete data acquisition project to review the resources for effective participation in Clinical Audit.	Ongoing

Challenges

The Internal Audit Report on Clinical Audit published November 2022 gave the Health Board limited assurance. There has been ongoing work to fully embed clinical audit within clinical teams. Working collaboratively with the Divisional Management teams, Directorates and Clinical Leads will ensure the Clinical Audit Strategy is fully embedded and IA recommendations met.

The internal report highlighted that the current staffing establishment for clinical audit is under resourced. Whilst the use of AMaT has supported audit to be more efficient, the implementation of AMaT has been carried out by one member of the team. Current financial pressures have not allowed the opportunity to carry out a resource mapping exercise.

Local Audit plans have been developed in AMaT. Reporting of these by Divisions has been challenging. There are currently 95 local audits registered in the "WARD AREA" in AMaT. Many of these audits are replicated across all or many sites across the Health Board. There are also 124 registered local audits reported in AMaT Clinical area, some of these also cover many areas across the Health Board.

There has been lots of work by the audit team to look at the risk and assurance processes that underpin reporting of clinical audits. Further work will look at the new risk management policy and ensure audit risk is being captured in the same way. Currently, all audit Assurance and Risk levels are recorded and a record is made if the outcomes are also recorded on a Risk Register and at what level, this can be corporate or divisional. All this information is captured in AMaT and if a risk identified these audits are not signed off until a risk register entry has been formulated with appropriate risk mitigations.

Healthcare Quality Improvement Partnership (HQIP) future planning is set out 9 months ahead, using their publication schedule. This is updated in a timely manner but does not allow a two-year forecast as request by the assurance and audit committee.

All audits registered in AMaT will have recommendations which local actions plans are based on. Completion of these is monitored by the Quality and Patient Safety Clinical Audit Lead. Continued tracking of these actions has been made easier by AMaT, but still involves chasing and following up by the audit team.

Clinical priorities superseding audit responsibilities remains a challenge for busy clinical teams.

Patient Experience captured through audit……..



More and more audits are taking into the account the views of patients. We are increasingly asking family, carers and friends, what they thought of the treatment provided by the Health Board and how we can improve this.

Dimensions of Person-Centred Care

Through this Strategy, the Health Board are committed to:

- Respecting people's values, preferences and expressed need
- Improving information and education
- Improving access to care
- Improved provision of emotional support to relieve fear and anxiety
- Involving family, friends and people who matter to the individual
- Providing continuity and secure transition between healthcare settings
- Providing physical comfort
- Delivering co-ordinated care

"I was reluctant to share my story but seeing how you have used my feedback and made the changes you have is really encouraging. Thank you for listening".

National Audits with patient related quality improvement measures are:

- National Early Inflammatory Arthritis Audit (NEIAA)
- National Audit of Care at End of Life (NACEL)
- National Dementia Audit (NAD)

"Just because I had a good healthcare outcome, doesn't mean my experience was good. The NHS saved my life, but I felt embarrassed when my dignity wasn't preserved"

Key objectives for 2024/2025

- Continue to work closely with Divisions to develop local audit plan.
- Continue to fully embed AMaT and run additional training sessions and raise audit awareness.
- Contnue to develop governance and reporting structure within AMaT.
- Work on tracking of audit results and recommendations, ensuring actions and findings from national and local clinical audits are monitored at an appropriate forum and are utilised to inform future planning within the Health Board.
- Review mechanisms to triangulate the learning from clinical audits and other sources of information to improve services.
- Work collaboratively with the value based healthcare team to review impact of measures that compliment audit and benchmarking results.
- Work with patient experience and involvement team to review how CIVICA and patient experience data can strengthen audit data.
- Review our quality and safety structures and resource within the audit team and understand gap analysis for effective participation in Clinical Audit.

Conclusion

- Much has been achieved by the audit team in the last 12 months in implementing the Clinical Audit Strategy. The focus has been on working closely with Divisions, Directorates and Clinical leads to ensure clinical audit is prioritised. This remains a challenge with the competing priorities of managing service pressures and focusing on delivering patient focused services during a period of high demand.

- Throughout 2023/24 the Clinical Audit team have worked to raise the profile of Clinical Audit and to integrate it as part of core services and "business as usual".

- Implementation of AMaT has improved efficiency of audit completion and effectiveness of monitoring completion of actions arising from audit. Using AMaT to produce a standardised template for reporting, and SMART action plans has provided assurance to CSEG and PQSOC.

- This report contains a compendium of national audit reports for the last 12 months.

- Future work will ensure learning from audit is shared across the organisation and communicated to staff and patients.

- Patient experience, quality, and safety is at the centre of our work to secure improvement in the quality of care and services we deliver and to improve outcomes for the population we serve.

- Clinical audit is an important component of our EFFECTIVE commitments over the next three years to enable delivery of the Duty of Quality, as mapped to the six domains of quality. This will support the delivery of a sustainable and resilient health and care system in the wake of the Covid-19 pandemic.

Did you know……

One of first clinical audits was undertaken by Florence Nightingale during the Crimean War of 1853–55. On arrival at the medical barracks hospital in Scutari in 1854, Nightingale was appalled by the unsanitary conditions and high mortality rates among injured or ill soldiers. She and her team of 38 nurses applied strict sanitary routines and standards of hygiene to the hospital and equipment. Nightingale had a talent for mathematics and statistics. She and her staff kept meticulous records of the mortality rates among the hospital patients.
Following changes in infection control practice the mortality rate for injured soldiers fell from 40% to 2%, and the results were instrumental in overcoming the resistance of the medical establishment and officers to Nightingale's procedures. Her methodical approach, as well as the emphasis on uniformity and comparability of the results of health care, is recognised as one of the earliest programs of outcome management.



Appendices No.	Audit Name:
Appendices 1	National Lung Cancer Audit Annual Report (NLCA) (slides 19-24)
Appendices 2	National Heart Failure Audit (NHFA) (slides 25-32)
Appendices 3	Management of Heart Attack: analyses from the Myocardial Ischaemia 2023 Summary Report (MINAP)(slides 33- 41)
Appendices 4	National Audit of Percutaneous Coronary Intervention (NAPCI) (slides 42-44)
Appendices 5	National Paediatric Diabetes Audit (NPDA) (slides 45-54)
Appendices 6	Fracture Liaison Service Database (FLS-DB) Annual Report (slides 55-63)
Appendices 7	National Pregnancy in Diabetes Audit 2021 and 2022 (NPDA) (slides 64-73)
Appendices 8	National Diabetes Audit 2021-22, Type 1 Diabetes (NDA) (slides 74-79)
Appendices 9	National Diabetes Audit: Care Processes and Treatment Targets 2021-22 (Primary Care) (slides 80-87)
Appendices 10	National Neonatal Audit Programme (NNAP) Summary Report 2022 (slides 88-94)
Appendices 11	National Early Inflammatory Arthritis Audit (NEIAA) Year 5 State of the Nation Report 2023 (slides 95-102)
Appendices 12	National Vascular Registry State of the Nation Report 2023 (slides 103-110)
Appendices 13	National Prostate Cancer Audit (NPCA) State of the Nation report (slides 111-113)
Appendices 14	National Bowel Cancer Audit – NBoCA (slides 114-118)
Appendices 15	HQIP Planned Activity list for 2023/2024 (slides 119-123)

Appendix 1

Audit Title:	**National Lung Cancer Audit Annual Report** (for the audit period 2019 England, Wales and Guernsey and 2020 England only) Published January 2022	**Clinical Lead:**	**Dr Matt Jones Consultant in Medicine**
Rationale:	This National Lung Cancer Audit (NLCA) annual report provides information on the process of care and outcomes for patients diagnosed with lung cancer between 1 January 2019 and 31 December 2019 in Wales and Guernsey and between 1 January 2019 and 31 December 2020 in England. The NLCA forms part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP) funded by NHS England and the Welsh Government		
Objectives:	The purpose of the NLCA annual report is to understand the current quality of care and outcomes for patients with lung cancer. The report gives detailed analysis of 2,240 patients diagnosed in Wales in 2019.		
Presented at Clinical Standards and Effectiveness Group – 21st May 2023			

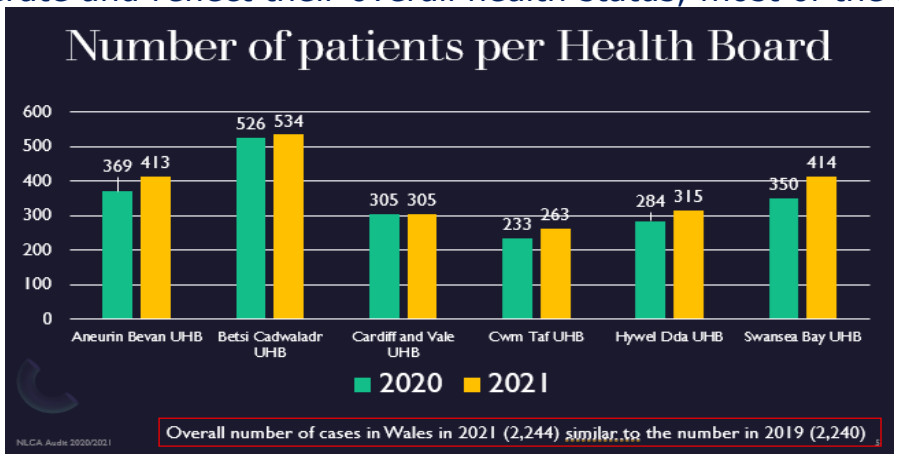
Results

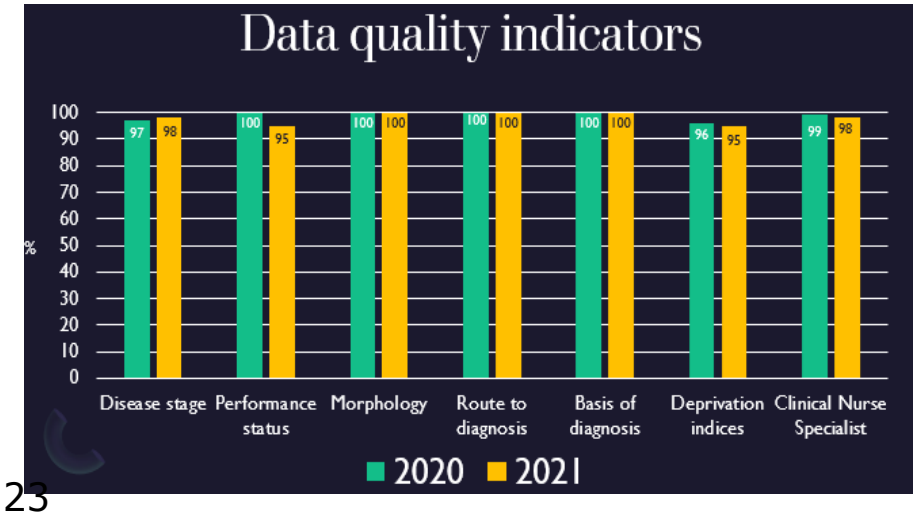
The Clinical Lead for this audit is Mr Mat Jones and the Health Board (HB) has a large Multidisciplinary Team (MDT) diagnosing over 400 cases for Lung Cancer per year, and the HB is the second largest MDT in Wales. Many patients are referred with end stage disease and with multiple co-morbidities placing a strain on the workforce. Early stage across Wales is very similar.

This data relates to 2020-2021 during the pandemic and is the first publication since the HB joined two MDT's, NHH and RGH, which had been pursued for a few years previously.

Data shows reduced numbers during 2020 and increased in 2021 and the HB is performing well in relation to Data Quality Indicators (graph below). The HB MDT are reliant upon Velindre Cancer Centre for oncology support and Cardiff & Vale for surgical support, this is where data integrity can cause issues.

The Performance Status (PS) is based on what the patient can do day to day and frailty index. This determines the type of investigations patient can tolerate and reflect their overall health status, most of the HB patients represented with stage two disease.

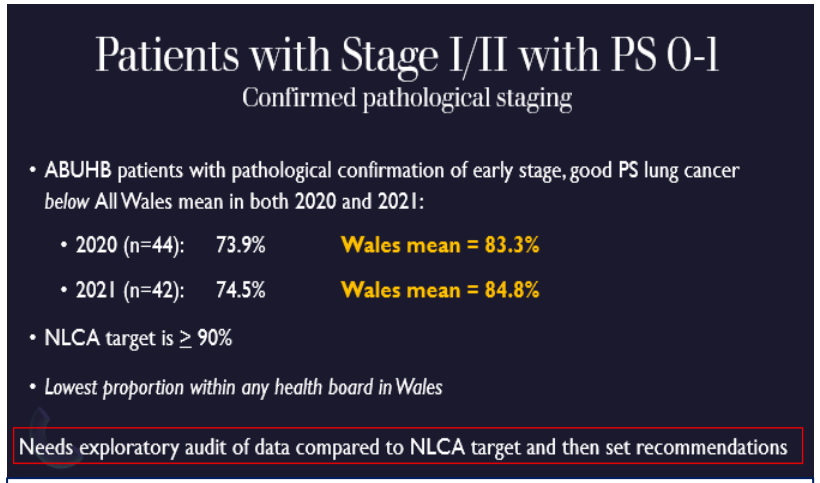




ECOG Performance Status Scale

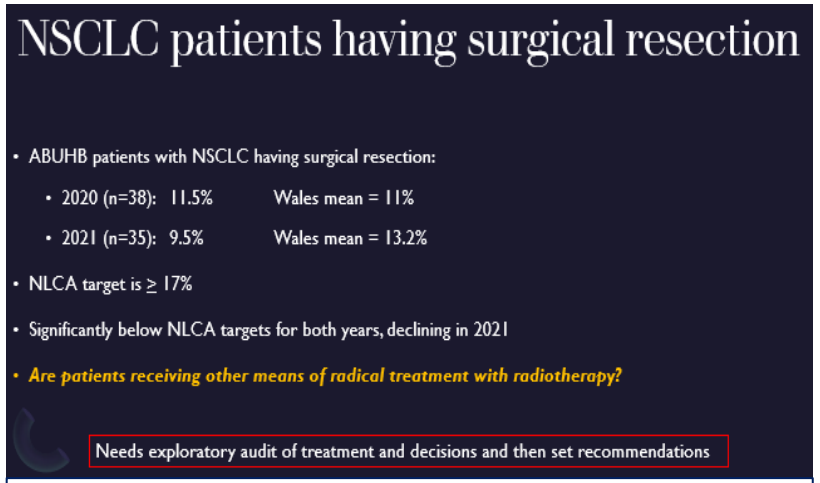
GRADE	ECOG PERFORMANCE STATUS
0	Fully active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work
2	Ambulatory and capable of all selfcare but unable to carry out any work activities; up and about more than 50% of waking hours
3	Capable of only limited selfcare; confined to bed or chair more than 50% of waking hours
4	Completely disabled; cannot carry on any selfcare; totally confined to bed or chair
5	Dead

Performance Status 3 and 4 outcomes are lower for the Health Board than the mean for Wales although the Health Board is higher than the Wales for PS 2.

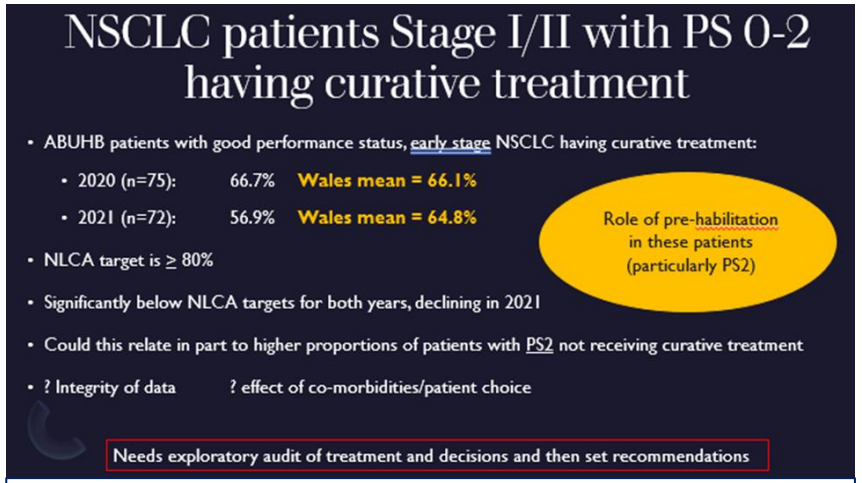


The target is high for patients with pathological confirmation of early-stage disease, Good PS lung cancer at 90% with the Health Board at 73.9% in 2020 and 74.5% in 2021, with the Wales mean at 83.3% and 84.8% for the same years, other characteristics of the patient can influence this result.

The HB currently has 5 Lung Clinical Nurse Specialists (LCNS) (not all 5 are WTE) working tirelessly to back up the service daily, and the number of patients seen exceeds the NLCA target of >90%.



For surgical resection target at 17%, however the HB was 11.5% and 9.5%, versus the Wales mean of 11% and 13.2%, below NLCA targets for both years, declining in 2021. The only HB performing well is Betsi Cadwaladr UHB. It is notable that this is the only HB where surgery is carried out in England



Non-Small Cell Lung Cancer (NSCLC) patients Stage I/II with PS 0-2 having curative treatment, are below NLCA targets for both years, declining in 2021, at 56.9% compared the Wales mean of 64.8% and the target of 80%.

SCLC patients having chemotherapy

- ABUHB patients with SCLC receiving chemotherapy:
  - 2020 (n=32): 50% Wales mean = 57.5%
  - 2021 (n=37): 67.6% Wales mean = 70.82%
- NLCA target is ≥ 70%
- Below NLCA targets for both years, improving in 2021 - ?Covid related
- Highly variable presentation with differences in PS and stage of disease potentially accounting for differences

Need to ensure rapid prioritisation of patients for investigation and treatment

Small Cell Lung Cancer (SCLC) is below NLCA targets for both years, improving in 2021 in the HB and across Wales. There is a need to ensure rapid prioritisation of patients for investigation and treatment.

NSCLC patients Stage IIIA with PS 0-2 having curative treatment

- ABUHB patients with good performance status, Stage IIIA NSCLC having curative treatment:
  - 2020 (n=29: 44.8% **Wales mean = 46.8%**
  - 2021 (n=41): 31.7% **Wales mean = 60.6%**
- No set NLCA target - England mean = 60% in 2021
- Declining proportion of patients in 2021 compared to 2020
- Could this in part relate to higher proportions of patients with **PS2** not receiving treatment
- ?Integrity of data ?effect of co-morbidities/patient choice

Heterogeneous population of patients with expanding treatment options

Needs exploratory audit of treatment and decisions and then set recommendations

The Stage IIIA with PS 0-2 having curative treatment has no set target although England's mean is 60% and the HB saw a decline in 2021 compared to 2020 and 2021 by almost half. The Health Board was 31.7% compared to the Welsh mean of 60.6%. This could be low for many reasons such as HB access to oncology, access to treatment options for these patients, effects of comorbidities, patient choice, documentation of data and potentially not offering patients curative therapy.

NSCLC patients Stage IIIB/IV with PS 0-1 having SACT

- ABUHB patients with good performance status, Stage IIIB NSCLC having SACT:
  - 2020 (n=69): 50.7% **Wales mean = 52.5%**
  - 2021 (n=68): 48.5% **Wales mean = 56.6%**
- NLCA target > 60%
- Below NLCA target and Wales mean in both years
- ***Could this relate to delays in obtaining pathology results on patients, oncology access, patient choice – many potential aspects to explore***

Needs exploratory audit of treatment and decisions and then set recommendations

NSCLC patients Stage IIIB/IV with PS 0-1 advanced disease where it's metastatic, spreading to outside of the lungs, having Systemic Anti-Cancer Therapy (SACT) below NLCA target and Wales mean in both years, this can also be impacted on by other factors such as co-morbidities and the HB has delays in the pathology pathway and rely on sending samples to Cardiff, if this was done within the HB, this would speed up the pathway getting results to patients quicker and possibly providing an option for oncological intervention before deteriorating to a lesser PS. Possible issues regarding therapeutic nihilism and patient choice, for exploration.

Assurance and Risk

Assurance level	Description	Select
Limited	The project did not achieve the standards or criteria being audited against	Yes

Risk level	Description	Select
Minor	Single failure to meet internal standards/Minor implications for patient safety if unresolved	Yes
Has this audit been placed on a Risk Register (N/A if above risk is None)		**NO**
If not on a risk register, why not? Actions ongoing		

Key Success and Concerns

	Report Successes:
1	Merging of MDTs across health board
2	Structured and streamlined services with adoption of Lung Cancer Physician of the Week (LCPOW)
3	High throughput of patients from multiple referral sources
4	Excellent input to patient care from nurse specialists

	Report Concerns:
1	High proportion of PS 2 patients
2	Low proportion of confirmed pathological staging for good PS, early stage disease
3	Below target treatment rates for surgical resection in NSCLC, SCLC chemotherapy, NSCLC Stage IIIA and NSCLC advanced stage good PS treated with SACT
4	Issues on data integrity – sources, validation

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Aim to achieve high levels of data completeness in the cancer registration datasets, particularly the Rapid Cancer Registration Dataset and COSD in England. - Completeness should be at least 95% for performance status (PS), ethnicity and disease stage, and at least 90% for "trust first seen", route to diagnosis, seen by a lung cancer clinical nurse specialist (LCNS) at diagnosis and smoking status (to highlight inequalities and inform future strategies).	Explore the data integrity	Mat Jones	31/12/2023	Ongoing
2	Ensure at least 85% of patients with stage I/II PS 0–2 NSCLC undergo curative intent treatment in line with NICE guidance.	Discuss at NDT		08/06/2023	Fully complete
3	Ensure at least 70% of patients with NSCLC stage IIIB-IV and PS 0-1 receive systemic anti-cancer therapy in line with NICE guidance.				
4	Ensure at least 90% of lung cancer patients are seen by a lung cancer clinical nurse specialist at diagnosis. NHS 5Resource lung cancer MDTs, according to the commissioning guidance set out by the Lung Cancer Clinical Expert Group and update the guidance to reflect current best practice.				

Appendix 2

Audit Title:	National Heart Failure Audit (NHFA) 2023 Summary Report (2021/22 data	Clinical Lead:	Linda Edmunds – Consultant Nurse, Cardiac Rehabilitation
Rationale:	This report summarises selected key findings from the National Heart Failure Audit (NHFA), part of the National Cardiac Audit Programme (NCAP). It deals with a specific and crucial phase in the disease trajectory of patients admitted to hospital with heart failure (HF) in England and Wales. There is a particular focus on a set of quality improvement (QI) metrics, based on standards and guidelines, which aim to drive up standards of care during an acute admission to achieve better patient outcomes.		
Objectives:	The National Heart Failure Audit collects data on all patients with an unscheduled admission to hospital in England and Wales who have a death or discharge with a diagnosis of heart failure in the primary position (i.e. heart failure is the main condition treated or investigated during the episode of care) with the following ICD-10 codes: • I11.0 Hypertensive heart disease with (congestive) heart failure • I25.5 Ischaemic cardiomyopathy • I42.0 Dilated cardiomyopathy • I42.9 Cardiomyopathy, unspecified • I50.0 Congestive heart failure • I50.1 Left ventricular failure • I50.9 Heart failure, unspecified. Patients admitted for elective procedures, for example elective pacemaker implantation or angiography, are not included. Patients must be 18-years and over to be eligible for inclusion in the audit. Patients who are discharged alive with a length of stay of less than one day e.g those who may have been treated in an Ambulatory Care Facility in the hospital, are included in the numerator and denominator for participation. However, they are excluded from the quality improvement aspects of the audit, as they do not remain long enough in hospital for the KPIs to be collected. They are tracked for mortality		
Presented at Clinical Standards and Effectiveness Group – 20th September 2023			

Key message 1:

- Echocardiography rates, for this key diagnostic test for heart failure (HF), have steadily decreased from the 90% level reported in the 2014/15 audit cycle to 85% in 2020/21. They have remained at the 85% level for the current 2021/22 cycle, for aggregate data, leaving 15% of patients without a secure diagnosis.

- There is considerable variation in echocardiography use between hospitals with only 51% of hospitals meeting the >90% audit target, a 3% increase from the 2020/21 cycle, but one that requires improvement.

- Marked variation in echocardiography use within institutions is also noted. Patients admitted to cardiology wards are more likely to have echocardiography than those admitted to general medical wards (92% versus 82%). Patients admitted elsewhere, but receiving specialist input to their care, have lower echocardiography rates at 89%, but considerably better than the 67% rate for patients not receiving any input from the HF specialist team. The echocardiography rate is less good in older patients, aged >75, at 83%, and overall women fare less well than men with rates of 83% and 86%, respectively.

Key message 3:

- HF patients are amongst the highest risk cardiac patients admitted to hospital, with their outcomes transformed by care on a cardiology ward and/or access to specialist HF cardiology and nurse care elsewhere. In this audit cycle, only 47% were admitted to cardiology wards (aggregate data), similar to the 48% reported in the 2020/21 audit cycle and not meeting the >60% audit target, whilst only 15% of individual hospitals met the target but with variation from 0-100%. 82% of patients were seen by a HF specialist during the admission, similar to the 81% of cycle 2020/21, and meeting the audit target of >80%, for aggregate data, but only 61% of hospitals met the target, down 4% on the previous audit cycle, with marked variation between hospitals.

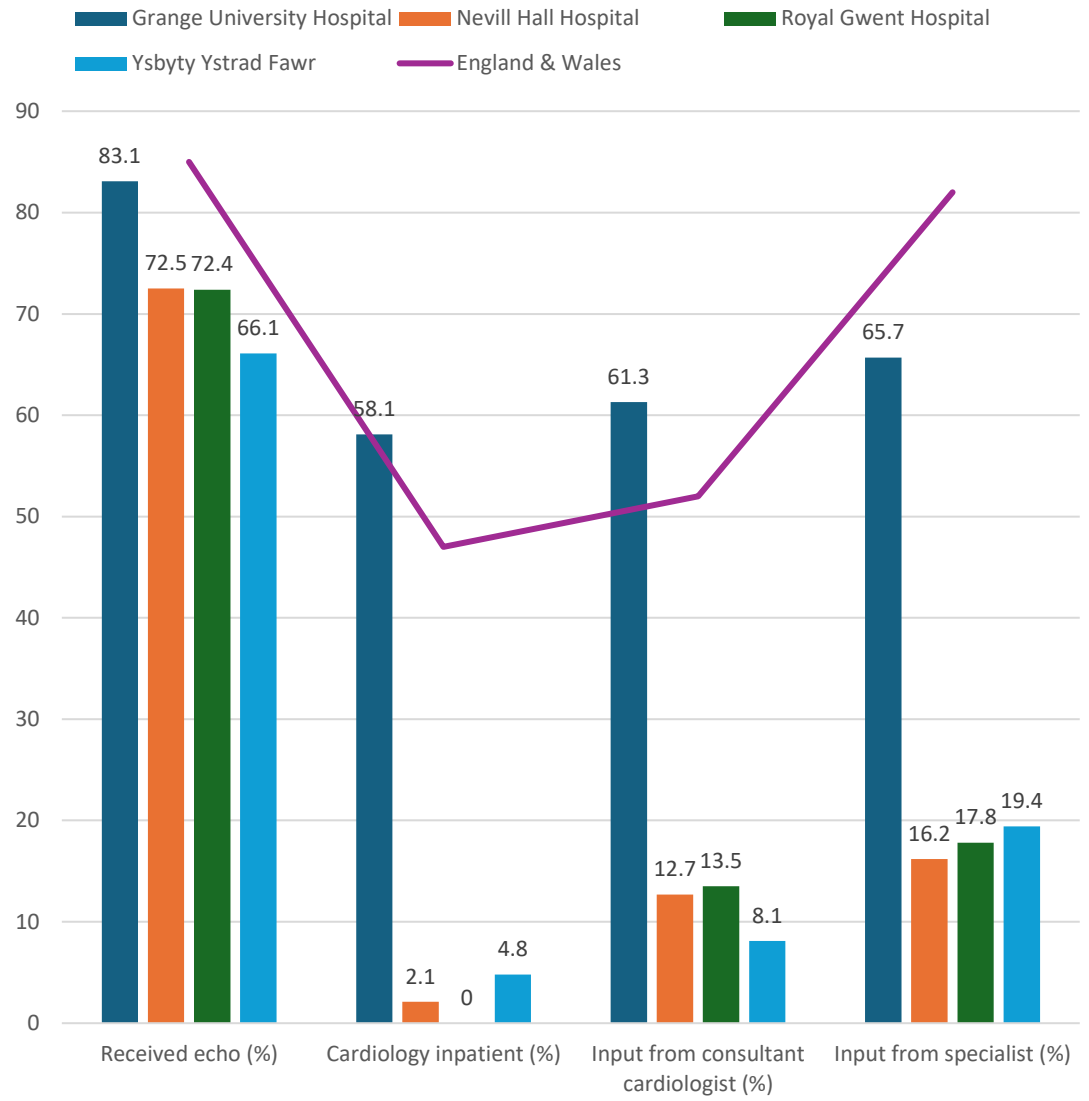
- For those on Cardiology wards, 99% were seen by specialists, 92% were seen by a consultant cardiologist, a substantial improvement from the 83% of the previous cycle, and 52% were seen by HF nurses, a figure that has not changed. In contrast only 72% of patients on General Medical wards were seen by 'Any HF specialist', with 51% seeing a specialist HF nurse compared with 46% last year.

Key Message 1 & 3 – Aneurin Bevan UHB

The above chart shows that the Health Board sites are not meeting the target of >90% receiving an Echo, in Grange University Health Board (GUH) where there is a higher rate of Inpatient admission to a cardiology ward, the rate receiving Echo is 83.1%. This is consistent across Wales with the main hospital site recording higher rates than the smaller sites. 5 hospital across Wales are meeting the target.

Patients in the main sites are more likely to be seen by a consultant cardiologist/specialist. Within the Health Board Nevill Hall Hospital (NNH) and the Royal Gwent Hospital (RGH) provide Echo at a similar rate (72.5% & 72.4% respectively), with Ysbyty Ystrad Fawr (YYF) rate 66.1%.

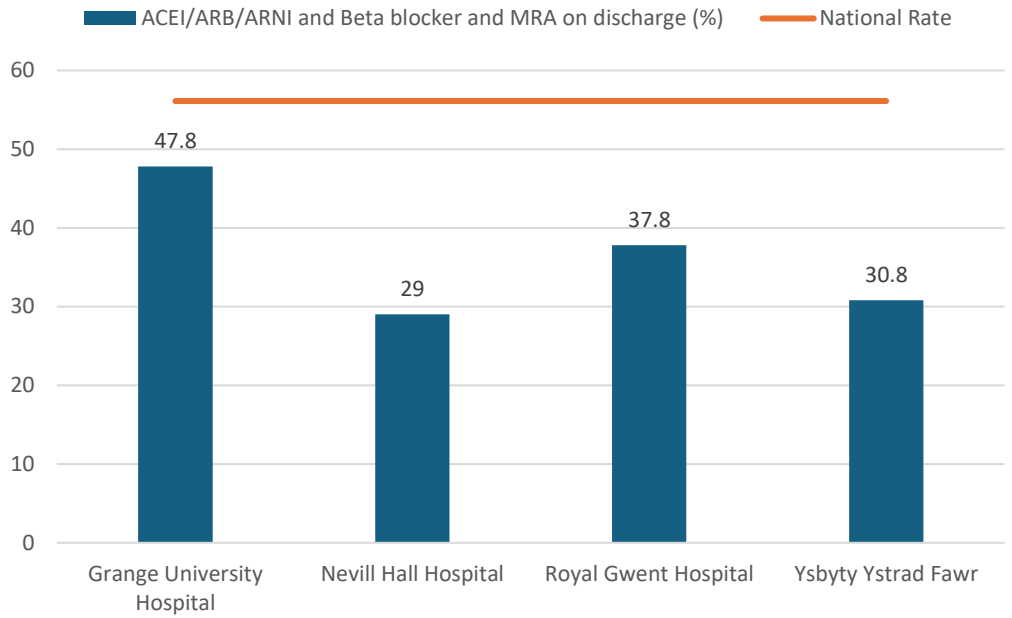
The Health Board is consistent with the message of patients are more likely to receive and Echo if admitted to a cardiology ward, with those having specialist care on other wards more likely to receive Echo.



Key message 2:

- This year the percentage of patients with heart failure attributed to systolic dysfunction (HF with reduced Ejection Fraction - HFrEF) discharged on the three classes of disease modifying therapy drugs (ACEI/ARB/ARNI, and BB and MRA) has increased from the 54% in 2020/21 (for ACEI/ARB and BB and MRA) to 56% this year for aggregate data. There remains considerable variation in prescribing patterns for the combination of, and for each of, these drugs within hospitals and between hospitals. A sharp decline in recommended prescribing in those above the 55-64 age group is again reported, though for those aged >85 beta-blocker prescribing is relatively well maintained at 84.1%.

- The introduction of a revised data set, for this audit cycle onwards, allows data collection on newer drugs for HFrEF, including the angiotensin receptor/neprilysin Inhibitor (ARNI) and for the first time the use of the sodium-glucose co-transporter-2 (SGLT2) inhibitors, dapagliflozin and empagliflozin reflecting the new and emerging evidence base. In the first cycle there has been only limited adoption of the new dataset but as this increases the data for these drugs will become more secure and will be reported in more detail.

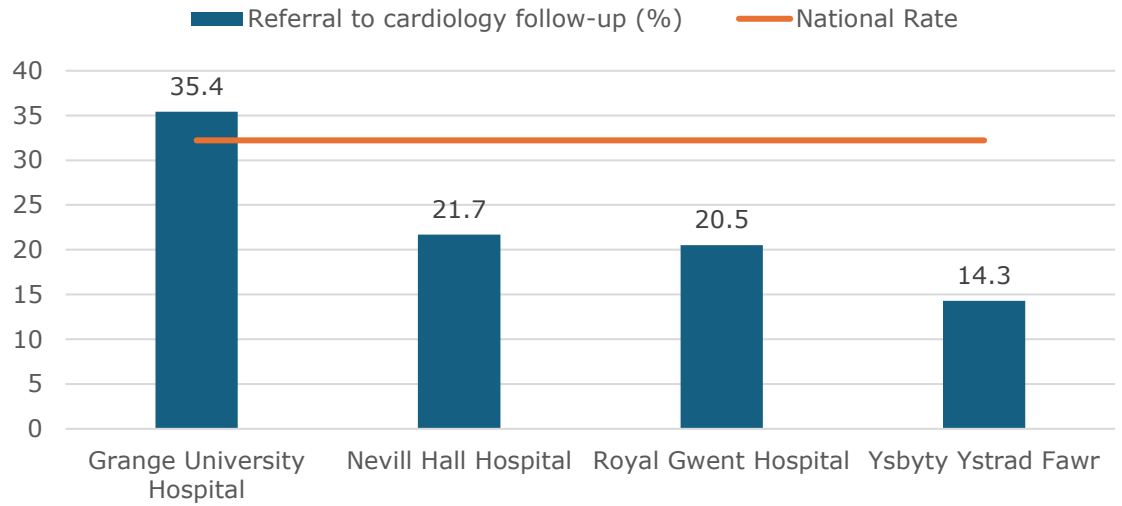


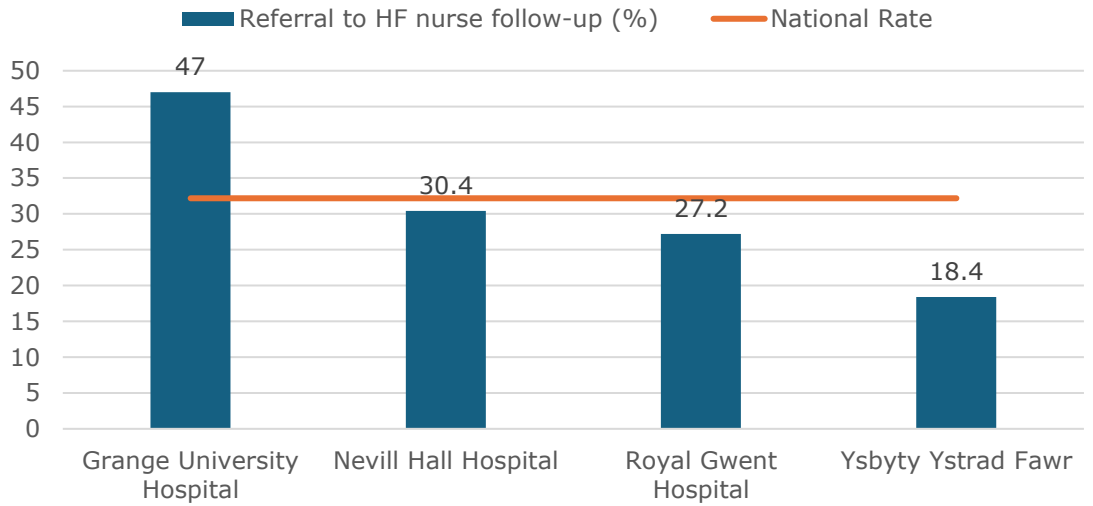
Key Message 2 - Aneurin Bevan UHB

The National Average rate for discharge on three disease modifying therapy drugs is 56% and all sites within the Health Board are beneath this rate with considerable variation across the Health Board and compared to the rest of Wales, the Health Board has some of the lowest rates, 4 sites within the bottom 7 of 16 hospitals.

Key message 4:

- Patients are especially vulnerable in the early discharge period. This is reflected in the audit standard of 100% specialist follow-up within two-weeks. Trends for both cardiology and HF nurse follow-up were decreased in the COVID-pressured audit cycle of 2020/21, when compared with the previous cycle. This audit cycle (2021/22) shows a further drop of 7% so that only 32% had cardiology follow up. The improvement of 11% since last year in timely HF specialist nurse follow up to 58% is positive but does not compensate for the lack of cardiology follow up. Timely specialist follow up in this cycle overall also fell to 40%, from 43% in the 2020/21 cycle.





Key Message 4 - Aneurin Bevan UHB

With the audit standard set at 100% for specialist follow-up, the Health Board is significantly under this, however GUH is performing better than the national average for both referral to cardiology and heart failure nurse follow-up at 35.4% and 47% respectively.

Key message 5:

- A unifying theme to address all these points would be early and continuing involvement of the specialist team as first outlined in the NICE guidance of 2014.

Assurance and Risk

Assurance level	Description	Select
Significant	The project has mostly achieved the standards or criteria being audited against	Yes

Risk level	Description	Select
Moderate	Repeated failure to meet internal standards/Major patient safety implications if findings are not acted on	Yes
Has this audit been placed on a Risk Register (N/A if above risk is None)		**NO**
If not on a risk register, why not? Actions ongoing		

Key Success and Concerns

Report Successes:	
1	Pathways in accordance with guidelines
2	Roll out of Inpatient Heart Failure service
3	Rehabilitation Hub encouraging patient self-management and reducing specialist time for complex cases
4	Improved optimisation of medication reviews
5	Reduced 30-day re-admission rates

Report Concerns:	
1	Medication on discharge rates

	Report Recommendations:	S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Hospitals not achieving the recommended standard for the use of in-patient echocardiography for patients with acute heart failure (HF) should urgently review their clinical pathways and ensure that echocardiography is performed, ideally within the first 48 hours of admission.	The Health Board Echo rates have improved since the reduction due to the pandemic and with outsourcing the Health Board can deliver a prompter service. The inpatient heart failure service as commenced gradually throughout the sites, with the GUH to join next year, to see patients within 24 hours of referral. These patients are on International Consortium for Health Outcomes Measurement (ICHOM) pathways based on Clinical Reported Outcome Measures (CROM). Treatment can be commenced earlier commencing the four-pillar medical therapy and placed on heart failure pathway ensure two week follow up.	Mrs Linda Edmunds	21/09/2023	Fully complete
2	High-risk cardiac patients, including those with heart failure, should have access to a cardiology ward.	Patient pathways are currently being addressed.	Mrs Linda Edmunds	31/03/2024	Ongoing
3	Hospitals not achieving the standards for ensuring that a patient with acute HF is seen by a HF team should review their pathways of care and consider a quality improvement programme to improve their performance. Hospitals without a clinical lead for heart failure should appoint one (ideally a consultant cardiologist with sub-specialty training in HF). The lack of a named lead should feature on their risk register.Hospitals without access to specialist HF nurses in their hospital team or in the community should urgently seek to appoint them.	There are two cardiologists with a specific interest in Heart Failure and Specialist Nurses working as a team.	Mrs Linda Edmunds	21/09/2023	Fully complete

Report Recommendations:		S.M.A.R.T Actions:	Responsible: Due Date: Progress:
4	All patients with HFrEF should receive best-practice disease-modifying drugs unless there is a contra-indication. Treatment is improved by patients being managed on cardiology wards or being seen by a HF specialist team, early during an admission, and ensuring patients are not prematurely discharged from hospital. Those hospitals not meeting the expected standards should perform a clinical pathway review to investigate where improvements can be made. Hospitals should make every effort to record all medications at discharge and avoid entering 'unknowns' in their audit submissions.	This is an area of concern for the Health Board and needs further work as this is strong component of heart failure care and will be addressed as part of the inpatient service rolling out and more patient being discharged on the four therapies. This is an education program that will be reviewed at the service progresses. Data shown comparing figures from 2021 to 2023 and YYF improved from 17% to 30% and an increase from 34% to 38% for the RGH, however there was a significant reduction at NHH, from 70% to 29% this was due to a retirement of a cardiologist.	Mrs Linda Edmunds 31/03/2024 Ongoing
5	Patients should be referred for Cardiology and Specialist HF Nurse follow-up, ideally leaving hospital with their first appointment. Hospitals should review their pathways for referral to cardiac rehabilitation to allow greater access and uptake for HF patients.	This is expected to improve with the inpatient service rollout and with a rise in referrals caused a delay in the programme, however the team have caught up and currently at 2-3 weeks follow up, with continuous improvement. All patients are offered face to face, or telephone follow up and patients under heart failure nurse have access to the MDT. National funding for a 12-month period for rehabilitation for Caerphilly area, and changed the model of care giving, and introducing a heart failure hub to encourage self-management. Rehabilitation staff are supported by the heart failure service. The hubs offered care closer to home and freeing up the heart failure clinical nurse specialist to concentrate on the more complex cases. Rehabilitation rates increased for 4% to 25% (national target 33%). This reduced optimisation of medication then 14 weeks from 79 weeks and improved the 30-day re-admission rate, for the Health Board was 11% and now down to 1%. Funding has been secured to roll this out across the Health Board.	

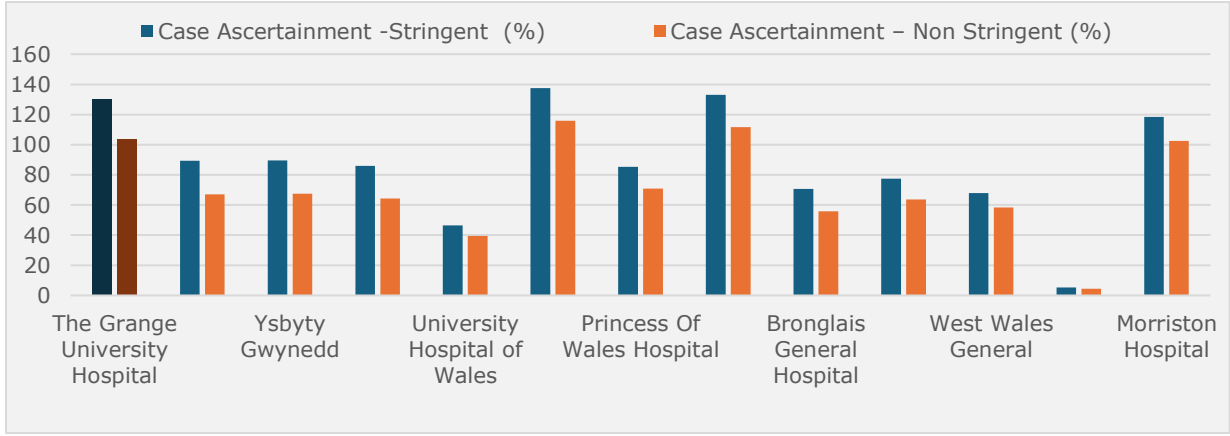
Appendix 3

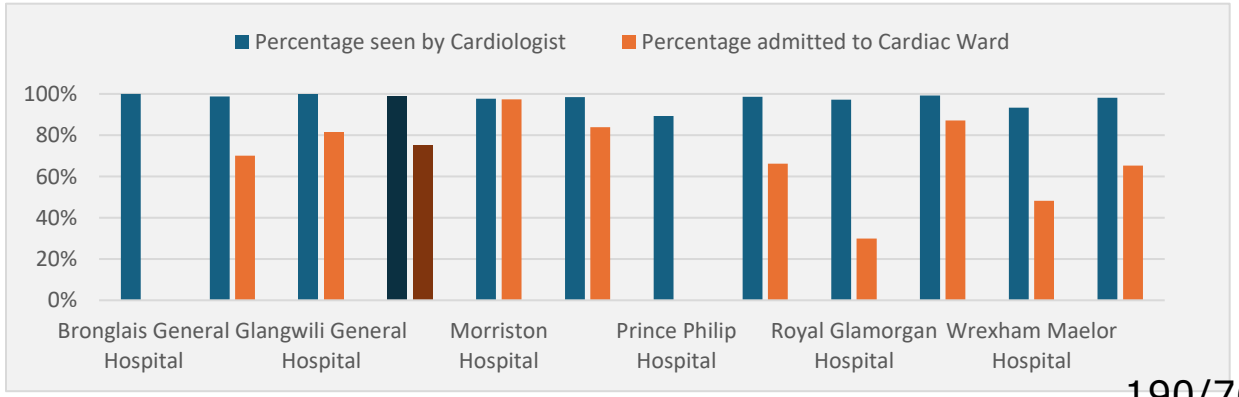
Audit Title:	Management of Heart Attack: analyses from the Myocardial Ischaemia 2023 Summary Report - 2021/2022 Data	Clinical Lead:	Dr Nigel Brown
Rationale:	This report summarises the care provided within hospitals in England, Wales and Northern Ireland to over 85,000 people who suffered a heart attack during the 2021/22 financial year.		
Objectives:	Quality of care is assessed against a set of quality improvement (QI) metrics derived from national and/or international standards and guidelines. These cover patients diagnosed with higher-risk ST-segment elevation myocardial infarction (STEMI) heart attacks and those with non-ST-segment elevation myocardial infarction (NSTEMI) heart attacks. The data used are drawn from the Myocardial Ischaemia National Audit Project (MINAP) and the National Audit of Percutaneous Coronary Intervention (NAPCI), both of which are part of the National Cardiac Audit Programme (NCAP).		
Presented at Clinical Standards and Effectiveness Group – 21st September 2023			

Results - Key Findings

Case ascertainment figures for MINAP	
STEMI	102
NSTEMI	439
Total	541
PEDW cases stringent	415
CA Stringent %	130.36%
PEDW cases non-stringent	521
CA non-stringent	103.84%

(N.B. CA Stringent % is greater than 100%. This is due to the numbers submitted to MINAP versus those on PEDW so linked to delayed or inaccurate Clinical Coding. 541 MINAP submission versus 415 PEDW. This will be looked at by the QPS audit team with cardiology.



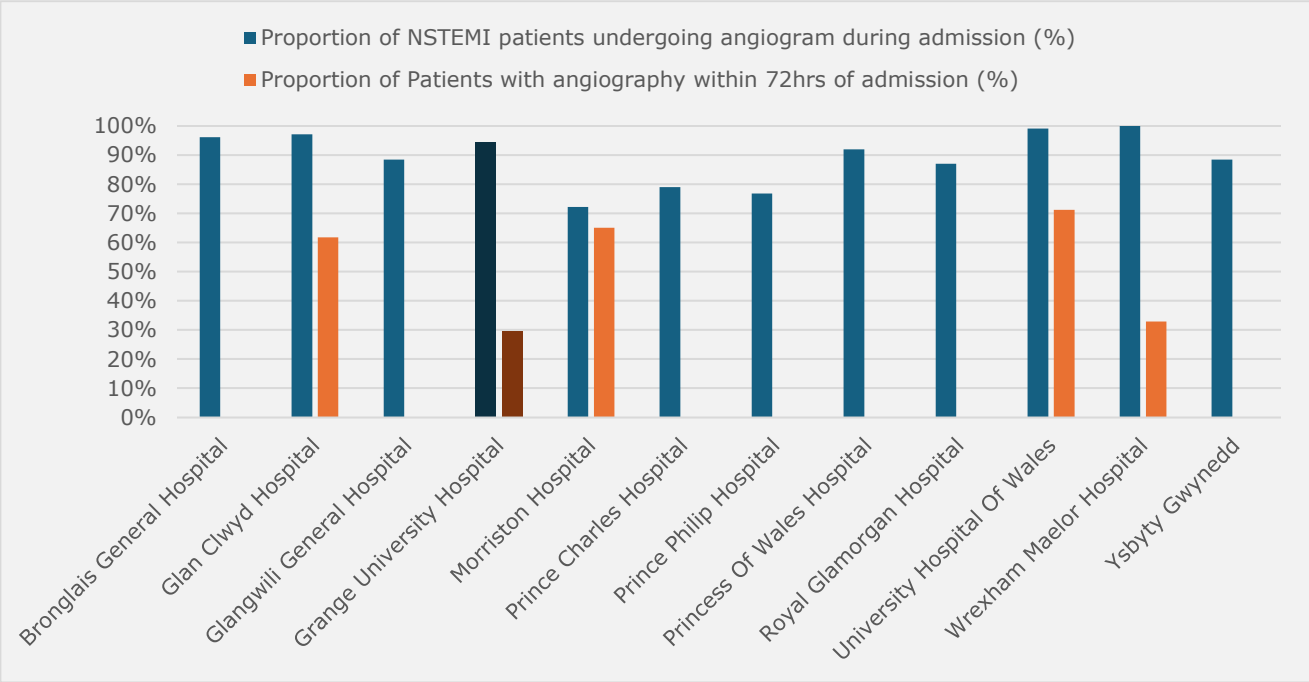


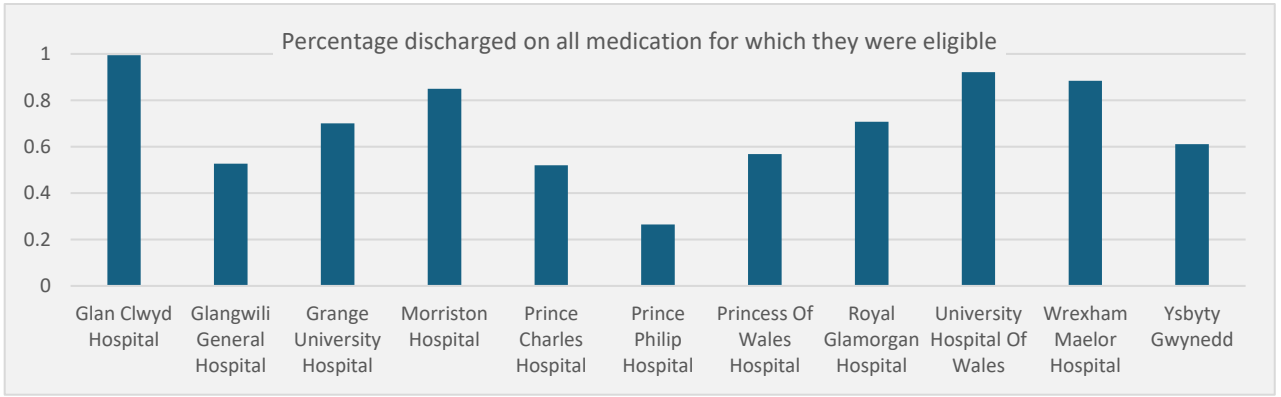
- **Proportion of Patients with angiography within 72hrs of admission (%)**

ABUHB 29.56%, 7 out of 12 Welsh hospitals performance is not reported as there are fewer than 20 eligible patients, the median between the 5 scoring HB's was 48.96% with the target set at 66%.

Performance of hospitals with respect to prescription of secondary prevention medication at time of discharge home to patients with either STEMI or nSTEMI.

Action - Delays to angio/PCI will be discussed at Cardiology Directorate meeting and added to the risk register. This risk will increase further if current financial constraints continue and may hamper major improvement. The Directorate will also be undertaking a more detailed look at MINAP regarding legitimate delays (not in the formal annual report) to understand the impact on waiting times.





Performance of hospitals with respect to prescription of secondary prevention medication at time of discharge home to patients with either STEMI or nSTEMI.

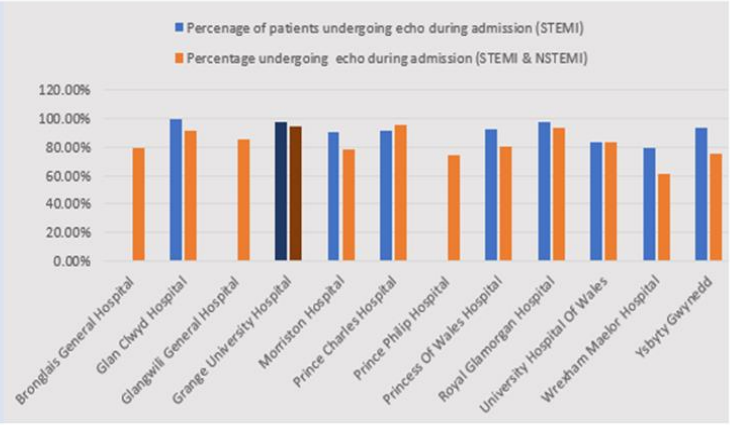
- **Percentage discharged on all medication for which they were eligible for ABUHB is 70.13% compared the Welsh Median of 70.44%. The National result is 89%.**

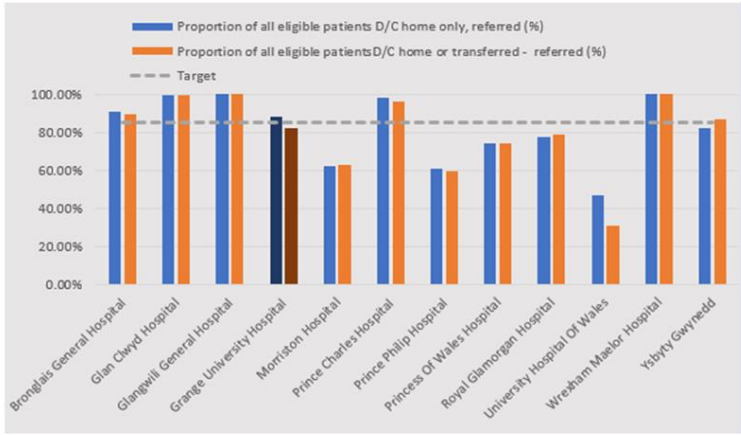
Action - We've historically done well on secondary prevention medicines at 70% equal to the Wales average this year. N.B. this may equate to only one out of 4 drugs. This may relate partly to the addition of aldosterone antagonists into a combined single data metric and/or relate to poor documentation on drug intolerance or legitimate reasons not to prescribe. We should not be complacent as a Directorate, and it requires a deeper look and perhaps a checklist for discharge meds should be considered and developed alongside our pharmacy lead.

Primary PCI

It is noted that the number of cases for ABUHB is fewer than 20 due to Grange University Hospital (GUH) not being a designated Heart Attack Centre, patients are sent to UHW, Cardiff. GUH will provide primary PCI opportunistically to a limited number of patients, which does provide data relating the Door to Balloon time (DTB) and Call To Balloon Time (CTB), both of which are significantly higher in minutes than the Heart Attack Centres.

Performance of an echocardiogram in patients with a final diagnosis of either STEMI alone, or STEMI and NSTEMI combined, during admission for **ABUHB is 97.96%** compared to the **Welsh Median of 92.59%,** this is based on 9 of the 12-hospitals providing this service. Combined STEMI and NSTEMI undergoing Echo for **ABUHB is 94.64%** compared to all **12 Welsh hospitals median of 81.84%.**





Performance of hospitals with respect to referral of patients with either STEMI or NSTEMI to cardiac rehabilitation programmes, for patient discharged home, **ABUHB is 88.37%** compared to the **Welsh Median of 85.34%**, with the inclusion of patients transferred to another hospital as well as discharged home, **ABUHB is 82.39%** where the **Welsh Median is 84.56%. The UK national result is 85%.**

National Key Messages:

Key message 1:
The overall number of cases of heart attack reported this year, 85,630. This is 16% higher than the previous year, and represents a 'bounce-back' to 'pre-pandemic' levels.

Key message 2:
Proportions both of patients referred to cardiac rehabilitation programmes following heart attack and of eligible patients receiving an echocardiogram prior to discharge from hospital are at the highest recorded level. Referral to rehabilitation exceeds the aspiration that 85% of patients should being referred.

Key message 3:
Percutaneous coronary intervention (PCI) is used, appropriately, in the majority of cases despite a greater number of patients being managed this year – immediate (primary) PCI in 84% of cases of 'high-risk' STEMI heart attacks; urgent PCI in 83% of lower-risk NSTEMI heart attacks.

Key message 4:
A smaller proportion of patients receive PCI in a timely fashion. For STEMI, the proportion of patients receiving primary PCI fell to 30% within 120 minutes, and to 55% within 150 minutes, of calling for help. For NSTEMI, whereas 66% underwent angiography within 72 hours of admission to hospital in 2020/21, performance has returned to pre-pandemic levels; 56% of patients with NSTEMI received an angiogram within 72 hours in 2021/22.

Key message 5:
A larger proportion of patients make their own way to hospital, rather than arriving by ambulance. While this represents the minority (18.6%) of all cases of heart attack, there appears to be an upward trend in self-presentation during the year. For those with STEMI undergoing primary PCI, the monthly proportion who self-presented to hospital rose from 4% during April 2021 to 8% during March 2022. The proportion of patients requiring transfer between hospitals for primary PCI rose from 14% in 2020/21 to 18.7% in 2021/22. These patients are less likely to receive timely primary PCI.

Assurance Level and Risk Level

Assurance level	Description	Select
Significant	the project has mostly achieved the standards or criteria being audited against	✓

Risk level	Description	Select
Minor	Single failure to meet internal standards/Minor implications for patient safety if unresolved	✓

Has this audit been placed on a Risk Register (N/A if above risk is None) Actions being managed within the service.	**No**

Key Success and Concerns

Report Successes:	
1	Achieving most targets, including high provision of echocardiography.
2	Case ascertainment has improved considerably.
3	High levels of assessment by a cardiologist and angiography.
4	High referrals rates for rehabilitation.

Report Concerns:	
1	Delays to angiography/intervention.
2	Delays in step-ups from eLGH's.
3	Staffing levels and catheter laboratory constraints.

	Report Recommendations:	S.M.A.R.T Actions:	Responsible: Due Date: Progress:
1	Where CTB time standards are not being met in STEMI cases, emergency departments, PCI centres, neighbouring non-interventional hospitals and ambulance trusts should work together to reduce delays in the provision of primary PCI. This may include improving the hospital response to patient arrivals as well as pre-hospital Call-To-Door (CTD) times. Hospitals not able to offer primary PCI to patients with STEMI who self-present, especially if geographically remote from such services, should consider re-introducing care pathways that include immediate administration of intravenous thrombolytic drugs.	Currently the Health Board is designated a non-Heart Attack Centre, small numbers of PPCI are undertaken (mainly self-presenting patients during working hours) but the numbers are < 20 per annum and therefore not reported. Ensure harm e.g. events in patients waiting intervention captured Retrospective review of the MINAP database to better understand detail behind delays	Dr Nigel Brown 21/09/2023 Fully complete
2	Hospitals with lower rates of echocardiogram provision, for STEMI and NSTEMI, should ensure that their data are being collected accurately and, if needed, should identify opportunities for echocardiography during the index admission. Use of limited 'bedside' echocardiograms should be considered if there are difficulties obtaining timely detailed tests. Patients discharged to another hospital before an echocardiogram is performed must be accompanied by a clear request for the test at the receiving hospital.	The Health Board performs very well with 94.64% of patients undergoing echo during admission (STEMI & NSTEMI). This reflects excellent work by the Physiology Team at Grange University Hospital (GUH)	

Report Recommendations:		S.M.A.R.T Actions:	Responsible: Due Date: Progress:
3	Hospitals not sufficiently admitting heart attack patients to a cardiac ward should review their systems and bed allocations to maximise access to cardiac care. This may require novel use of dedicated multi-specialty 'high care' beds and provision of cardiac outreach services to those cared for elsewhere.	The proportion of patients admitted to a cardiac ward in ABUHB is 75.4%. This compares favourably to the national average of 64%. Please note this figure represents admission within 24hrs so delays on the assessment unit or patients awaiting transfer from eLGH sites reflects the remainder and sits at approximately 24.6%. The cardiology team have developed a draft SOP which proposes an alternative use of additional bed capacity on B4 (currently GIM step down patients) to allow rapid transfer within 24hrs of all accepted eLGH patients.	Dr Nigel Brown 21/09/2023 Fully complete
4	Hospitals reporting low rates of cardiology involvement in heart attack patient care should ensure their data are accurately reflecting practice. If they do, provision of cardiac care during admissions should be improved (eg by increased staffing or more flexible use of members of the cardiology team, such as nurse specialists and physician associates).	ABUHB perform exceptionally well with 99 % of patients were seen by a cardiologist (97% nationally).	
5	Low rates of angiography in eligible NSTEMI patients require hospitals to review their systems for managing acute coronary syndromes (ACS).	ABUHB perform well with angiography during admission in 94.43% of patients (Wales median 90.1%, 83% nationally in UK)	

	Report Recommendations:	S.M.A.R.T Actions:	Responsible: Due Date: Progress:
6	Where angiography for NSTEMI takes more than 72-hours, hospitals and commissioners should review pathways, referral networks and service commissioning to make quality improvements. Any lessons regarding more timely care that were learned during the pandemic should be incorporated within existing pathways. There should be an emphasis on early and reliable identification of suitable patients, streamlined referrals, and adequate capacity for transferring patients into (and out of) interventional hospitals. This will involve weekend angiography lists for such patients.	29.6% patients underwent angiography within 72 hrs compared to a median of 49% in Wales and 56% nationally. A previous notional target of 60% had been set in England (tariff based). This figure does not take account of patients with legitimate reasons for delay such as anaemia or infection and the proportion of our patients with co-morbidities/legitimate delays may be higher and will be investigated further. Preliminary review of 2022-2023 data suggests approximately 25% will have a legitimate delay. Nevertheless, several issues that contribute to delays are listed in order of importance including; a) catheter laboratory time (elective patients/lists/complex case work/CTO's compete) and staffing constraints (medical, nursing, radiographer and physiology) b) delayed transfer from eLGH's (e.g.1 patient taking a week in 2022) c) weekend cover is limited to Saturday am so Friday admissions will generally wait more than 72 hours unless urgent. Ensure harm e.g. events in patients waiting intervention captured. Divisional discussion re investment in uplift in catheter laboratory capacity and possibly more formal "trigger points" for review of e.g., elective activity Report to be discussed in Quality Improvement Group and at divisional level and added to the risk register.	

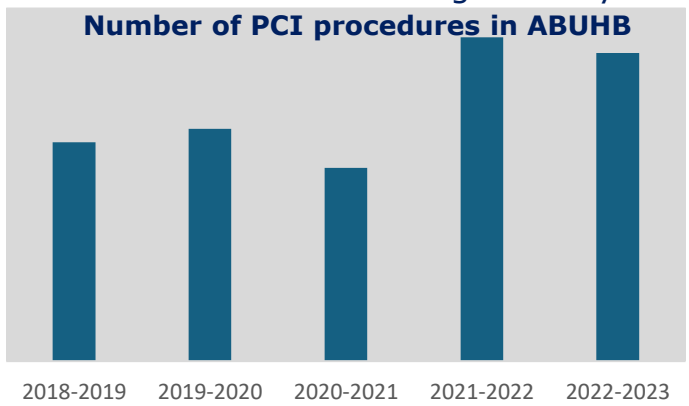
	Report Recommendations:	S.M.A.R.T Actions:	Responsible: Due Date: Progress:
7	Hospitals not meeting the prescribing standard for all secondary prevention medication prior to discharge of both STEMI and NSTEMI patients should assess the quality of their data and, if sub-optimal performance is confirmed, pursue quality improvement. These might include the use of discharge pro-forma or checklists, direct involvement of specialist cardiac pharmacists or ACS nurse specialists.	The percentage of patients discharged on all appropriate secondary prevention medication was 70.13%, identical to a median figure of 70.44% in Wales but lower than the UK average of 89%. This has fallen and may reflect issues with prescribing aldosterone antagonists in impaired LV function (newly added to this combined endpoint) but inadequate documentation of intolerance/CI (e.g., due to hypotension with ACE, or hyperkalaemia in the case of aldosterone antagonist's) or a legitimate decision not to prescribe. The MINAP database will be further analysed and we will discuss the role of an additional checklist on discharge.	Dr Nigel Brown 21/09/2023 Partially complete
8	Hospitals with lower rates of prescribing aldosterone antagonists for patients with impaired LV function identified by echocardiography (or some other reliable assessment method) should act to ensure appropriate treatment. This could involve discharge pro-forma/checklists and the direct involvement of specialist cardiac pharmacists, ACS nurses and sonographers.	This data for aldosterone antagonist's is now included within the standard above for secondary preventative medications. Clear documentation of medication decision may be an issue and will be the focus of another discharge medication checklist to put together with our pharmacy lead.	

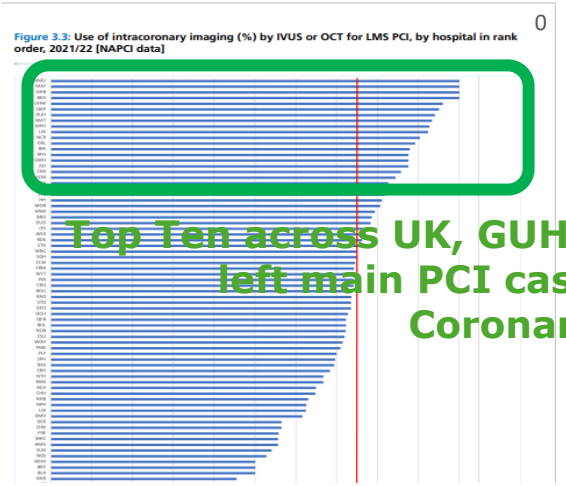
Report Recommendations:		S.M.A.R.T Actions:	Responsible: Due Date: Progress:
9	Hospitals not meeting the standards for referral of patients to cardiac rehabilitation following either STEMI or NSTEMI heart attacks should ensure early identification of patients who might benefit (eg through routine distribution of cardiac rehabilitation information/invitation in discharge checklists and in leaflets given to all patients). All hospitals should ensure equitable access to cardiac rehabilitation. Rehabilitation staff who were redeployed to ward-based duties during the pandemic should return to their original practices.	The percentage of patients discharged on all appropriate secondary prevention medication was 70.13%, identical to a median figure of 70.44% in Wales but lower than the UK average of 89%. This has fallen and may reflect issues with prescribing aldosterone antagonists in impaired LV function (newly added to this combined endpoint) but inadequate documentation of intolerance/CI (e.g., due to hypotension with ACE, or hyperkalaemia in the case of aldosterone antagonist's) or a legitimate decision not to prescribe. The MINAP database will be further analysed and we will discuss the role of an additional checklist on discharge.	Dr Nigel Brown 21/09/2023 Partially complete

Appendix 4

Audit Title:	National Audit of Percutaneous Coronary Intervention (NAPCI) April 2021-March 2022 Published June 2023	Clinical Lead: Dr Shawmendra Bundhoo
Rationale:	The NAPCI report reviews 97,765 PCI procedures which has increased by around 7000 procedures since 2020/21. PCI activity has recovered but has not returned to the numbers seen during the pre-pandemic. The report highlights the increased adoption of intracoronary imaging for PCI, involving the left main stem as per best practice guidelines, increasing use of same day discharge for elective cases and use of more potent P2Y12 inhibitors in PCI cases undertaken in patients with STEMI.	
Objectives:	The report focuses on several specific quality improvement (QI) metrics for the delivery of PCI services. These are derived from national and/or international standards and guidelines. A number of important metrics reported here which relate to the management of patients with acute coronary syndromes are also included in the joint MINAP/NAPCI Heart Attack report.	
Presented at Clinical Standards and Effectiveness Group – 21st March 2024		

Key message 1:
There has been an increase in the number of PCI procedures performed in the UK during this audit period (compared to COVID-19 pandemic 2020/21). Total PCI procedures increased by approx. 7,000, from 90,708 in 2020/21 to 97,765 in 2021/21. This represented a return to nearly 98% of the 100,112 cases reported in the pre-pandemic year. The number of primary PCIs for patients with ST-elevation myocardial infarction (STEMI) had returned to pre-pandemic levels. PCI for other acute coronary syndromes was virtually at pre-pandemic levels but elective PCI numbers were significantly lower.

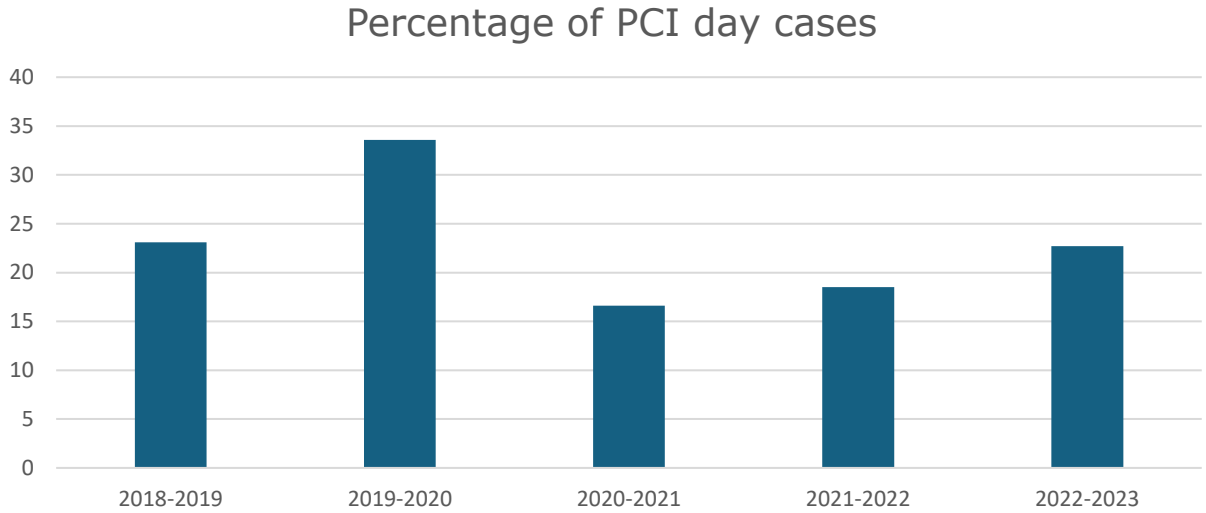


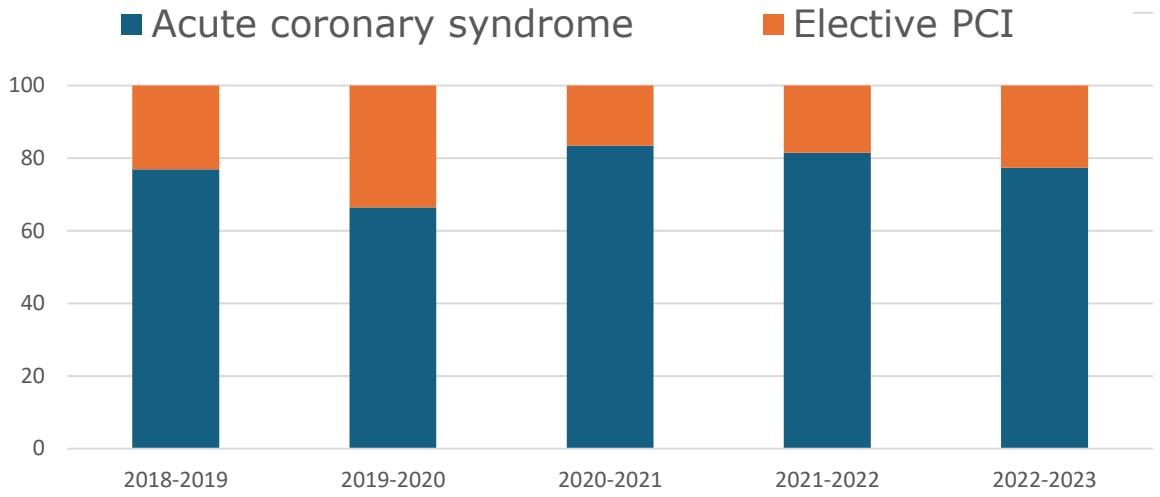


Top Ten across UK, GUH - 94% of all left main PCI cases had Intra Coronary Imaging

Key message 2:
There has been a gradual improvement in the use of intracoronary imaging from 50.7% in 2017/18 to 70.5% in 2021/22, although we report wide differences in practice between hospitals, with a number of units performing intravascular imaging in <50% of Left Main Stem (LMS) PCI.

Key message 3:
Day case PCI for elective procedures: There has been an increase in day case elective work over the last 4 years from 63.8% in 2018/19 to 71.4% in 2021/22, with significant variability nationally, with some centres performing day case PCI in almost all elective cases, and some where almost all patients are kept in overnight following their procedure. The Health Board is currently 22.7% elective same day discharge.





Key message 4:
There has been a significant increase in newer P2Y12 antiplatelet use over time, increasing from 44.2% use of prasugrel and ticagrelor in 2014 to 55.3% in 2021/22. The most commonly used newer P2Y12 agent in 2021/22 was ticagrelor (37.3%) and prasugrel was only used in 18% of cases.

- *Poor data capture*
- *Confusion between admission and procedure medications*
- *Planning to simplify data entry focusing solely on procedure pharmacology on Mc Kesson*
- *Ticagrelor is the drug of choice in ABUHB patients admitted with acute coronary syndromes who require PCI*
- *Clopidogrel is used instead of Ticagrelor when patient is on other anticoagulants namely novel oral anticoagulant agent or warfarin*
- *ABUHB patients undergoing primary PCI in UHW receive Prasugrel. Prasugrel is continued if repatriated patients require staged PCI in GUH*

Assurance level	Description
Full	The project has fully achieved the standards or criteria being audited against

Risk level	Description
None	Standards met and findings demonstrate no risk to patient safety

Report Successes:	
1	Compliant with national standards to perform unprotected left main PCI using intra coronary imaging
2	Same day discharges are occurring in >75% of elective PCI cases

Report Concerns:	
1	Need to have mandatory fields in Mc Kesson to capture dates of admission and discharge for elective cases
2	Limited data captured on antiplatelet pharmacology in patients presenting during daytime with STEMI

Report Recommendations:		S.M.A.R.T Actions: Responsible: Due Date: Progress:
1	Operators undertaking Left Main Stem PCI should use intracoronary imaging (either IVUS or OCT) to guide interventional strategy and optimise stent expansion and apposition, in line with international consensus statements around best practice.	This is current practice. No further action at present. To continue with current standard of practice.
2	Hospitals should modify their pathways and ward structures to maximise the use of day-case procedures so reducing avoidable overnight stays for patients.	Consistently >75% over the last 5 years – more complex cases post Covid-19. In order to modify services this requires more in-depth data capture for elective patients undergoing day case PCI. Clinical lead to progress.
3	Hospitals should review their STEMI protocols to see where improvements can be made in the use of newer antiplatelet agents, in particular Prasugrel, during primary PCI.	This will be captured when GUH will be offering a dedicated 24/7 Primary PCI service. All ABHUB patients who undergo PPCI at UHW receive Prasugrel. GUH is not a dedicated Primary PCI centre. Patients' self-presenting to GUH requiring Primary PCI receive Ticagrelor. Patients who are on anticoagulants requiring PPCI receive Clopidogrel to reduce the risk of bleeding complications.

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	To have certain mandatory parameters to be captured on Mc. Kesson for outpatient attendances to determine date of admission and discharge		Dr. S. Bundhoo		

Appendix 5

Audit Title:	National Paediatric Diabetes Audit (NPDA) Report on Care and Outcomes 2021/2022	Clinical Lead:	Dr Davida Hawkes
Rationale:	The NPDA is part of the National Clinical Audit Outcome Review Plan and is part of the NHS Digital directory of audits relating to Diabetes care. The effectiveness of diabetes care is measured against NICE guidelines (NG18, NICE 2015) and includes treatment targets, health checks, patient education, psychological well-being, and assessment of diabetes- related complications including acute hospital admissions, all of which are vital for monitoring and improving the long-term health and well-being of children and young people with diabetes. In 2021/22, 100% of paediatric diabetes teams participated in the NPDA.		
Objectives:	Its aim is to promote quality improvement in patient outcomes, and in particular, to increase the impact that clinical audit, outcome review programmes and registries have on healthcare quality in England and Wales. HQIP holds the contract to commission, manage, and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP), comprising around 40 projects covering care provided to people with a wide range of medical, surgical and mental health conditions. The programme is funded by NHS England, the Welsh Government and, with some individual projects, other devolved administrations and crown dependencies www.hqip.org.uk/national-programmes.		
Presented at Clinical Standards and Effectiveness Group – 20th July 2023			

National Paediatric Diabetes Audit - Aims and priorities:

- Build on and improve the previous joint adult and paediatric audit
- Collect a clinically meaningful dataset
- Engage clinicians, patients and parents
- Improve awareness of NPDA findings and maximise their use to drive national policy
- Develop the use of NPDA data in local and national quality improvements
- Use a regional network approach to data collection
- Capture patients' experiences
- Collaborate with the suppliers of the adult audit to ensure information around transition to adult care is captured
- Report at timely and regular intervals
- Develop user-friendly tools to interrogate the dataset
- Support centres wishing to develop local action plans to improve diabetes care
- Maximise the use and availability of data for research

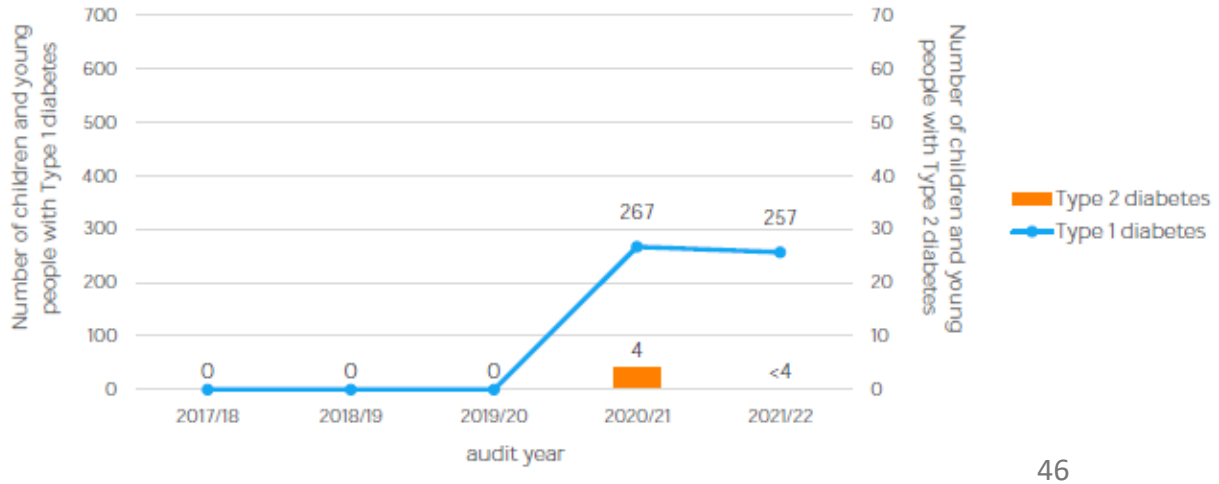
Results

- How many children and young people were receiving care from paediatric diabetes services in England and Wales in 2021/22?

The chart shows Grange University Hospital (GUH) data only.

2.5 Number of children and young people by type of diabetes, 2017/18 - 2021/22

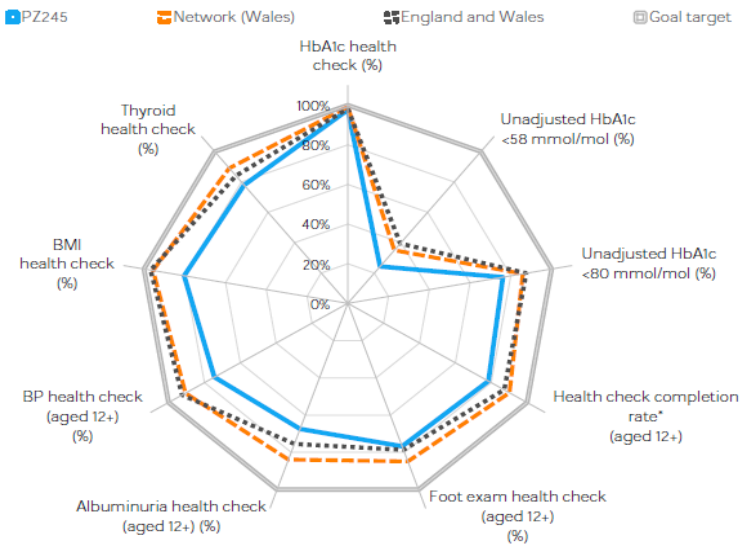
Figure 8: Number of children and young people according to diabetes type by audit year

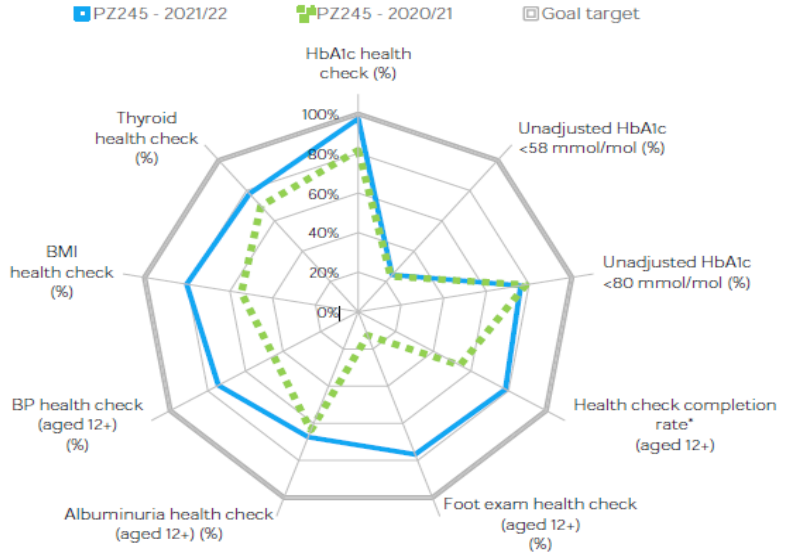


- What percentages of children and young people received all six recommended health checks in 2021/22?

The plots shows The Grange University Hospital (blue) compared to Wales (orange) and UK (black dotted line) and ABUHB 2021/2022 compared to 2020/2021.

1. HbA1c
2. BMI
3. Thyroid
4. Blood pressure
5. Albuminuria
6. Foot exam

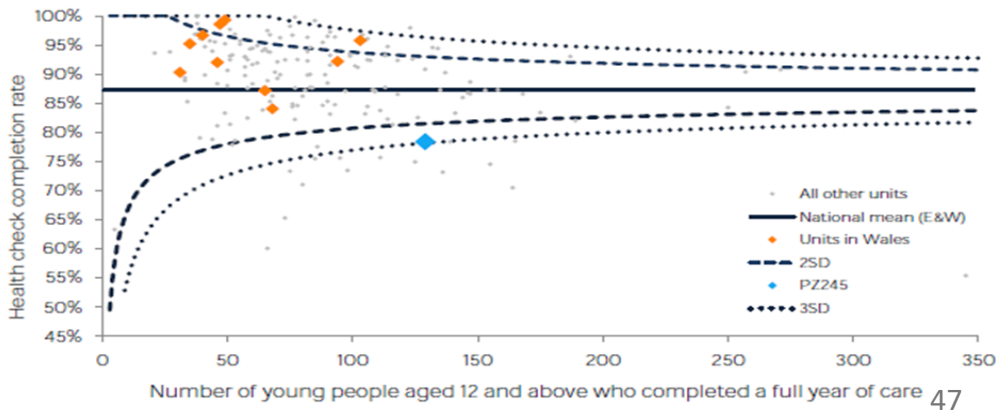




The outlier status of The Grange University Hospital, on the performance indicator for health check completion rate for 2021/22 is: **ALERT**.

The Clinical Lead (CL) presented the 2020/2021 report to the Clinical Standards and Effectiveness Group (CSEG) in September 2022 informing that the lack of face-to-face clinics resulting from the pandemic, was impacting on this result. During 2023 the face-to-face clinics have resumed and the impact should be seen in the next report.

Figure 12: Health check completion rate for children and young people with Type 1 diabetes aged 12 or older who completed a full year of care



- What percentage of all recommended health checks were delivered by PDUs in 2021/22? Outlier
- What percentages of children and young people with Type 1 diabetes received recommended checks at diagnosis in 2021/22?

The CL stated that the Carb Counting at diagnosis was a data entry error as this is commenced at diagnosis. This remains an issue and requires an action to ensure the data reflects accurately.

- Has there been longitudinal improvement in national HbA1c?

The GUH mean HbA1c for children and young people with Type 1 diabetes was 69.7 mmol/mol. The adjusted mean was 68.9 mmol/mol. The outlier status of The Grange University Hospital, on the performance indicator Adjusted Mean HbA1c for 2021/22 is: **ALARM**.

The CL stated in September 2022 that the lack of resource funding to manage the technologies for controlling HbA1c is impacting this target and the Health Board will remain an outlier until the cost for consumables linked to vital technologies needed for children to reduce their HbA1c, therefore improving their health as children and as they grow into the adult diabetes service. A collaborative business case submitted by adult services and the paediatric diabetes team which was supported however not funded.

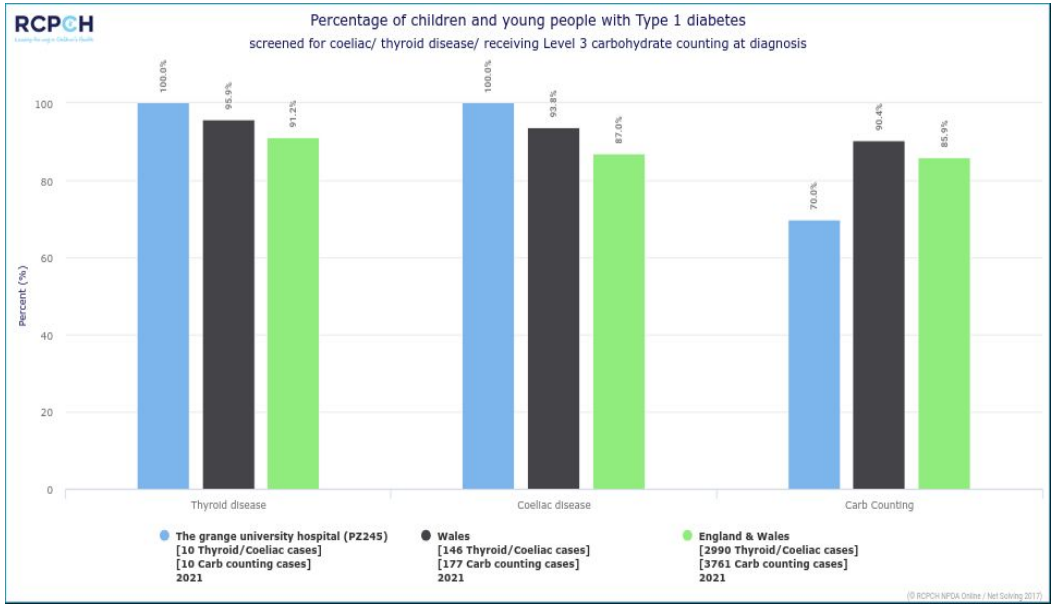
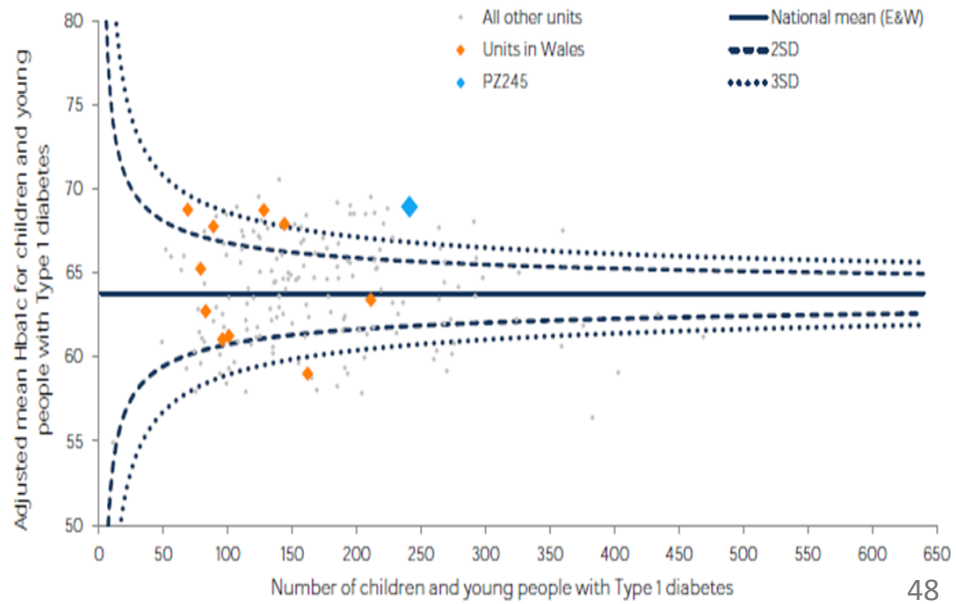


Figure 21: Adjusted mean HbA1c



- What percentages of children and young people with Type 1 diabetes were using diabetes-related technologies in 2021/22? Above plot chart - ALARM status.

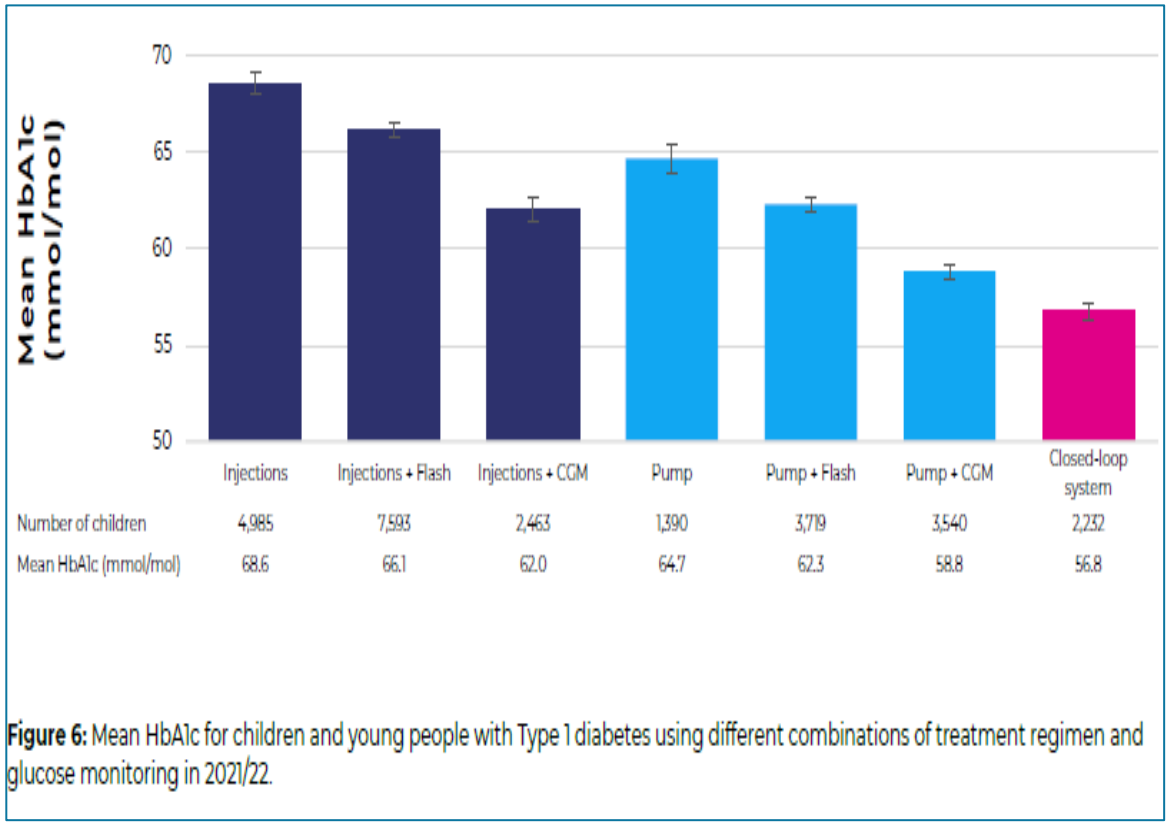
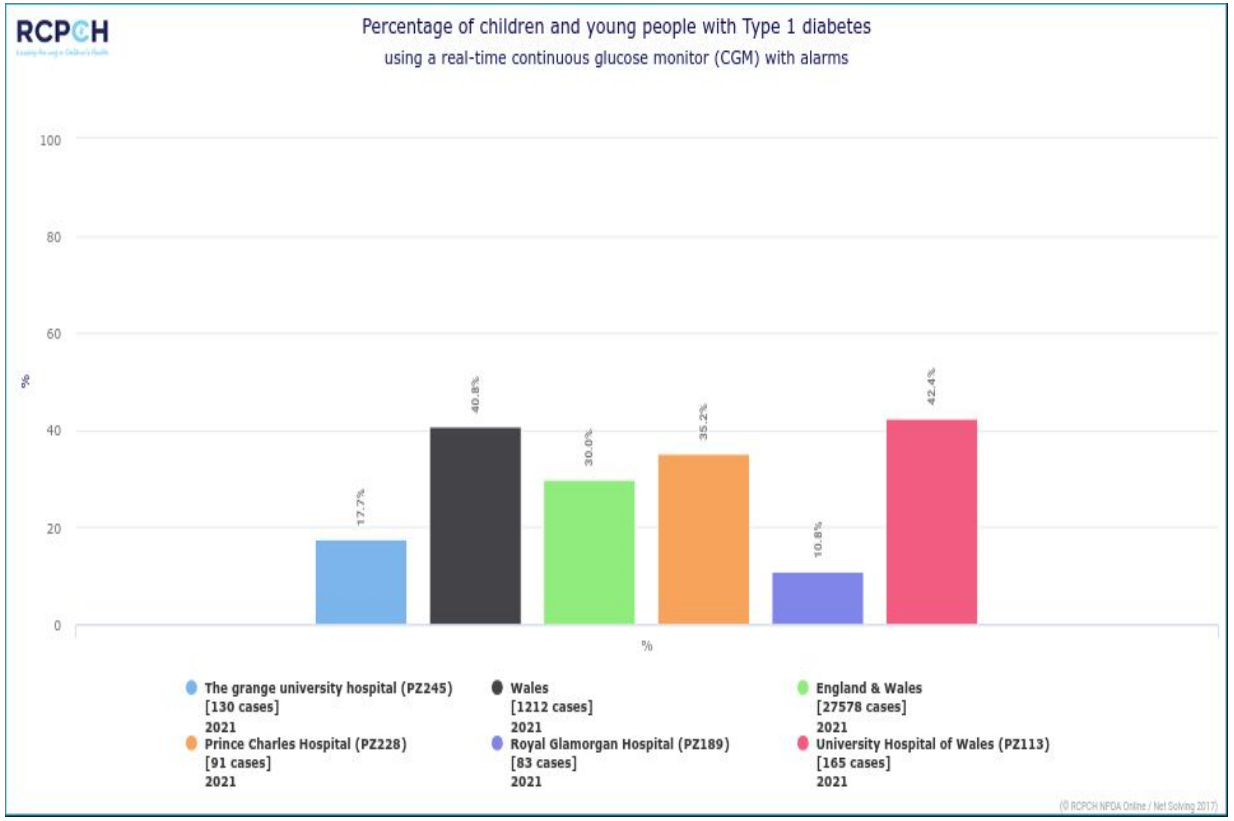
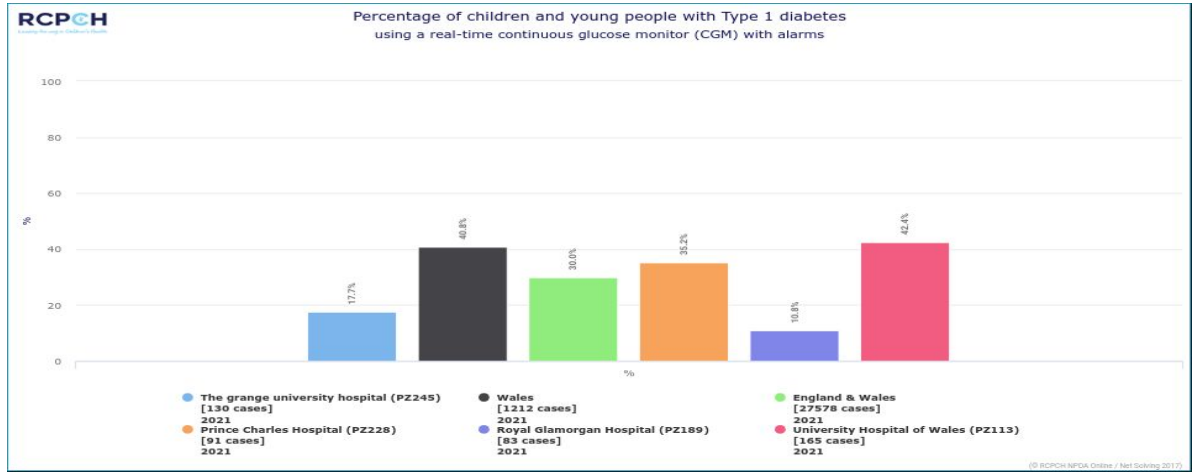


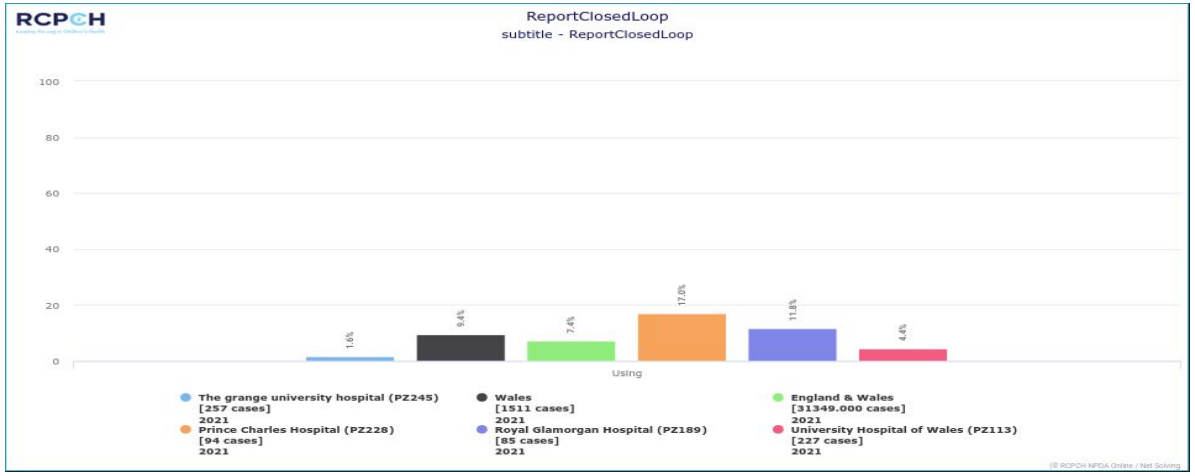
Figure 6: Mean HbA1c for children and young people with Type 1 diabetes using different combinations of treatment regimen and glucose monitoring in 2021/22.



- What was the average HbA1c for children and young people with Type 1 diabetes using different diabetes-related technologies in 2021/22?

The graphs below demonstrate the lower HbA1c when using advanced technologies across the UK and The Grange University Hospital displays low use of the technologies, therefore increasing and HbA1c and contributing to the ALARM status. This will not improve without the resources to obtain and manage the technologies.

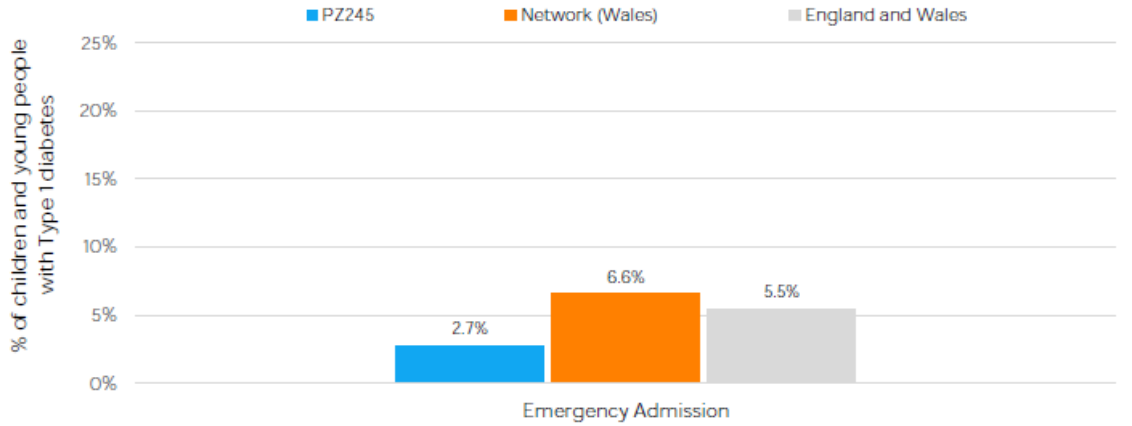




- What percentages of children and young people with Type 1 diabetes had diabetes-related hospital admissions in in 2021/22?

Percentage of children and young people with Type 1 diabetes who had at least one diabetes-related emergency hospital admission during the audit period, that was not associated with diagnosis.

Figure 39: Percentage of children and young people with Type 1 diabetes who had at least one diabetes-related emergency hospital admission during the audit period, that was not associated with diagnosis



- How many children and young people with diabetes were assessed as requiring additional psychological support following assessment in 2021/22?

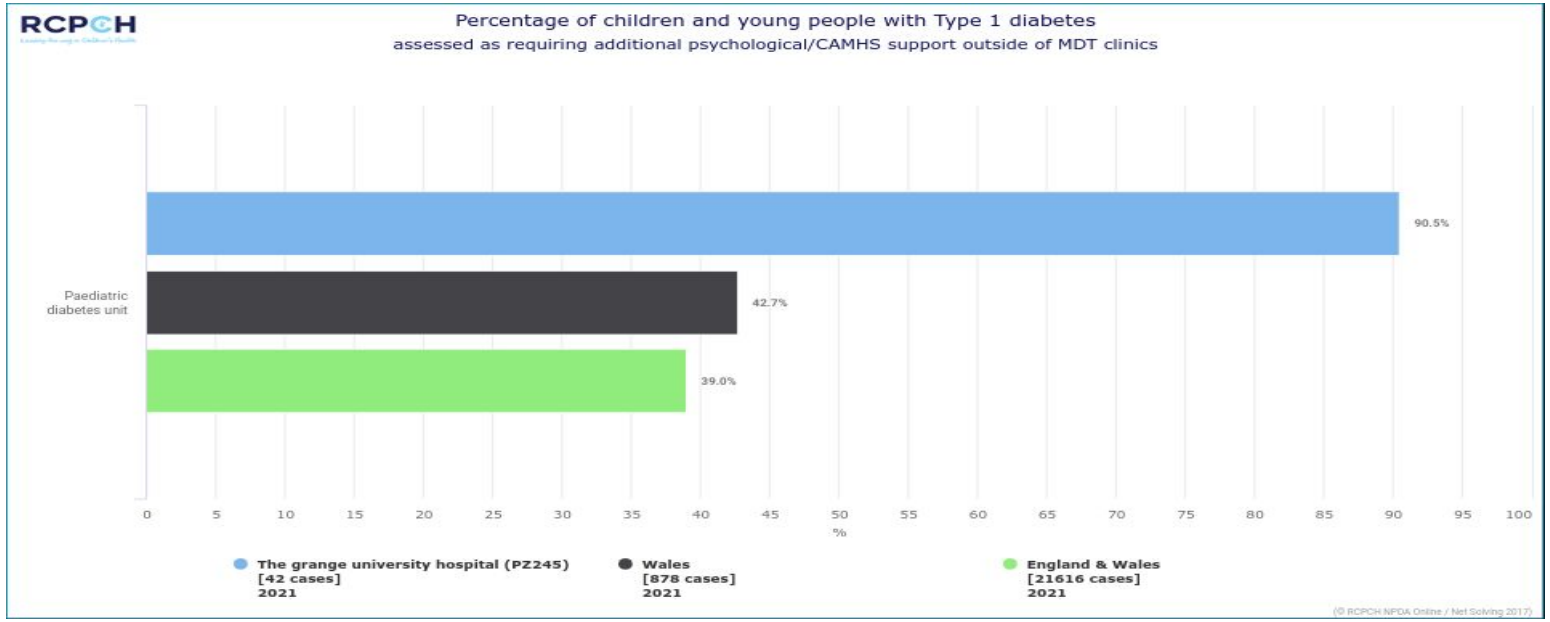
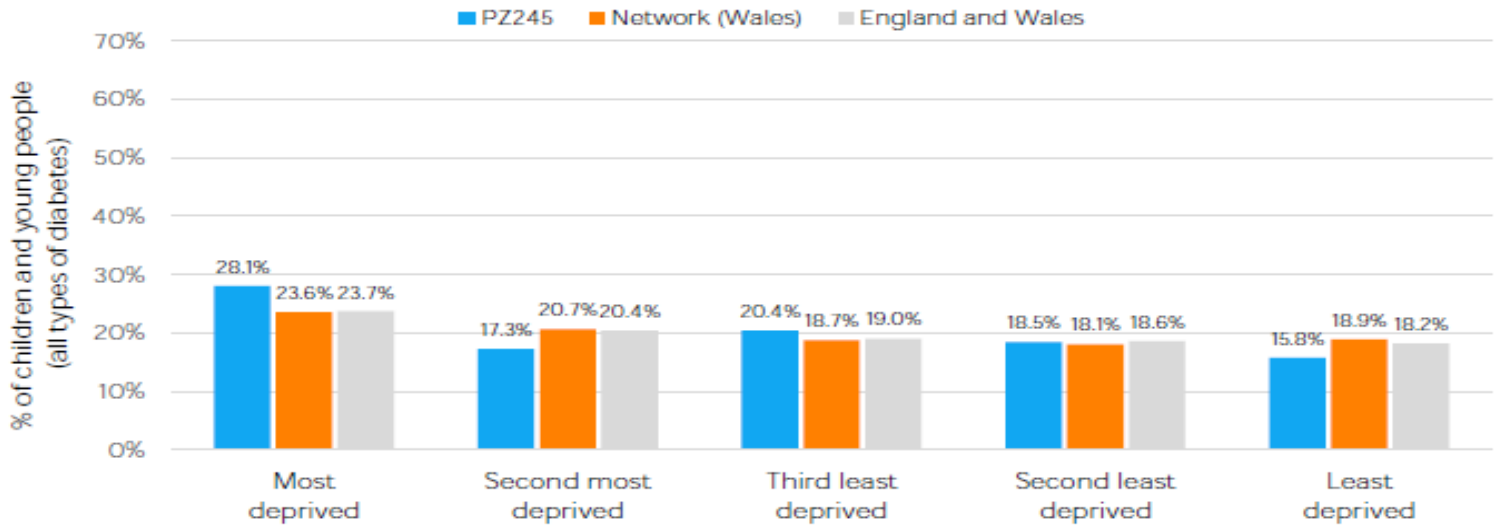


Figure 6: Percentage of children and young people within each deprivation quintile by unit, region and overall

Also noted is that Aneurin Bevan University Health Board a higher rate of CYP in the deprived areas compared to the rest of Wales and the UK.



*Calculated using Indices of Multiple Deprivation based on patient postcode

Assurance Level and Risk Level

Assurance level	Description	Select
Limited	The project did not achieve the standards or criteria being audited against	Yes

Risk level	Description	Select
Major	Non-compliance with national standards/Significant risk to patients if unresolved	Yes

Has this audit been placed on a Risk Register (N/A if above risk is None)	YES

Key Success and Concerns

Report Successes:	
1	The Paediatric Diabetes Team attended the Gwent Children's Diabetes Family Evening 2023. Attendees: Thirty-two families (80 people) initially confirm their attendance, with approximately 60 people attending on the evening. Great feedback.

Report Concerns:	
1	The outlier status of The Grange University Hospital, on the performance indicator for health check completion rate for 2021/22 is: Alert.
2	The outlier status of The Grange University Hospital, on the performance indicator Adjusted Mean HbA1c for 2021/22 is: Alarm.

Report Recommendations:		S.M.A.R.T Actions:	Responsible: Due Date: Progress:
1	Commissioners should ensure adequate staffing of full multidisciplinary diabetes teams to manage the increasing numbers of cases of Type 1 and Type 2 diabetes observed since 2020, who are trained to facilitate the optimal use of new diabetes-related technologies. Action by: Integrated Care Boards across England and Health Boards and Regional Partnership Boards across Wales.	The alarm status related to diabetes technologies, for the audit has been on the Divisional F&T risk register for some time. A joint business case submitted to PIP by adults and F&T was supported but not funded. Unfortunately, there has been no change to finances to be able to put in any additional workforce to improve this situation. Issues flagged at F&T Divisional Assurance meetings. The costs for consumables was reflected and the gap in ability to improve HbA1C levels still stand. Further actions from this is to submit the costs associated to diabetes to be submitted to Chief Operating Officer (LW). This will be undertaken jointly by both adults and paediatric finance teams. Risk to remain of register and further work as above. PQSOC to be made aware of risk when submitting audit activity report Work underway to address the gap in access to pump technology for Gwent children and young people with diabetes.	Ms Sara Garland 28/03/2024 Partially complete
2	Children and young people with Type 1 diabetes should have equitable access to diabetes care, irrespective of social deprivation, ethnicity or geography. They should be offered a choice of diabetes technology that is appropriate for their individual needs with families being made aware of the potential differences in outcome with different modalities of insulin delivery and blood glucose monitoring. Action by: Integrated Care Boards across England in line with the aims for diabetes care set out within Core20PLUS5 – the national NHS England approach to reducing health inequalities for children and young people. Health Boards and Regional Partnership Boards across NHS Wales and Public Health Wales. The RCPCH, to provide a better understanding of ethnic and social deprivation variability.		
3	Health checks for children and young people with diabetes are essential for early recognition of complications. The need for tests and the results should be clearly communicated to families as part of their individual care package, and completion rates of checks should be monitored through the year. Action by: Clinical teams within Paediatric Diabetes Units in NHS Health Boards and Trusts across England and Wales.		

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
4	Awareness of diabetes symptomatology amongst the public should be enhanced to avoid newly diagnosed children and young people presenting with Diabetic ketoacidosis (DKA). Action by: The Office for Health Improvement and Disparities, NHS England, Public Health Wales and NHS Wales supported by the National Children and Young People's (CYP) Diabetes Network, and diabetes charities (Diabetes UK and JDRF).				
5	Studies should be funded to derive evidence for interventions supporting pre-diabetic children young people to avoid progression to Type 2 diabetes. Action by: Funding bodies such as the National Institute for Health and Care Research, Diabetes UK.				

Are there any potential barriers/problems to prevent the implementation of the above actions?
Yes
If yes, please describe and detail who these have been referred to:
Insufficient funding for Diabetes team work load. Business Case was supported in principle for this but not funded. Trying to prioritise against need given situation Will explore opportunities for broader approach across Paediatrics

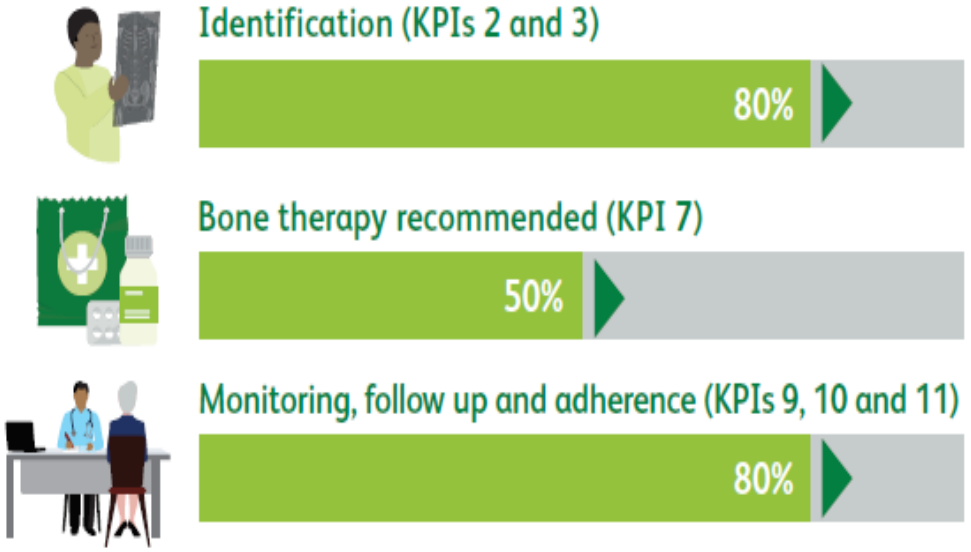
Appendix 6

Audit Title:	**Fracture Liaison Service Database (FLS-DB)** **Annual report: Rebuilding FLSs to meet local patient need** **Data from January to December 2021** **January 2023**	**Clinical Lead:**	**Dr Inder Singh** **Sophie Maggs/Amara Williams/Ketan Vegad, COTE team** **Non Pugh/Johanna Wiles, Rheumatology team**
Rationale:	A fracture liaison service (FLS) ensures that patients aged 50 and over with a broken bone after a fall have their bone health and falls risk checked and managed to lower their risk of a subsequent fracture. Made up of a team of healthcare professionals, FLSs bring clear benefits to the patient in the long term and have been shown to be clinically and cost-effective.		
Objectives:	FLS-DB collects, measures and reports on 11 key performance indicators (KPI's) derived from NICE technology appraisals and guidance on osteoporosis and falls alongside the Royal Osteoporosis Society (ROS) Clinical Standards for FLSs and Quality Standards for Osteoporosis and prevention of fragility fractures. The KPI's are: • KPI 1 – Data completeness • KPI 2 – Identification (all fragility fractures) • KPI 3 – Identification (spinal fractures) • KPI 4 – Time to FLS assessment • KPI 5 – Time to DXA • KPI 6 – Falls assessment • KPI 7 – Bone therapy recommended • KPI 8 – Strength and balance training • KPI 9 – Monitoring contact 12–16 weeks post fracture • KPI 10 – Commenced bone therapy by first follow up • KPI 11 – Adherence to prescribed anti-osteoporosis medication at 12 months post fracture		
Presented at Clinical Standards and Effectiveness Group – 25th May 2023			

	National 2019	National 2020	National 2021	ABUHB 2019	ABUHB 2020	ABUHB 2021
KPI 1 – Data completeness						
KPI 2 – Identification (all fragility fractures)	36.4	33.9	37.9	13	18.7	22.6
KPI 3 – Identification (spinal fractures)	17.6	14.5	20.3	18.1	26.2	26.1
KPI 4 – Time to FLS assessment	68.6	64.2	66.5	14.7	3.3	21.3
KPI 5 – Time to DXA	46.8	22.7	31.2	47.6	16.7	23.3
KPI 6 – Falls assessment	61.3	58.4	60.8	22.8	18.8	34.7
KPI 7 – Bone therapy recommended	52.6	52.3	55.2	50.5	55.9	57.7
KPI 8 – Strength and balance training	6	5.1	5.6	.8	1.5	4.8
KPI 9 – Monitoring contact 12–16 weeks post fracture	20.3	23.3	24.5	0	0	1.4
KPI 10 – Commenced bone therapy by first follow up	22.6	28.5	29	21.3	11.9	8.3
KPI 11 – Adherence to prescribed anti-osteoporosis medication at 12 months post fracture	20.4	23.1	22.3	17.8	5.4	18.4

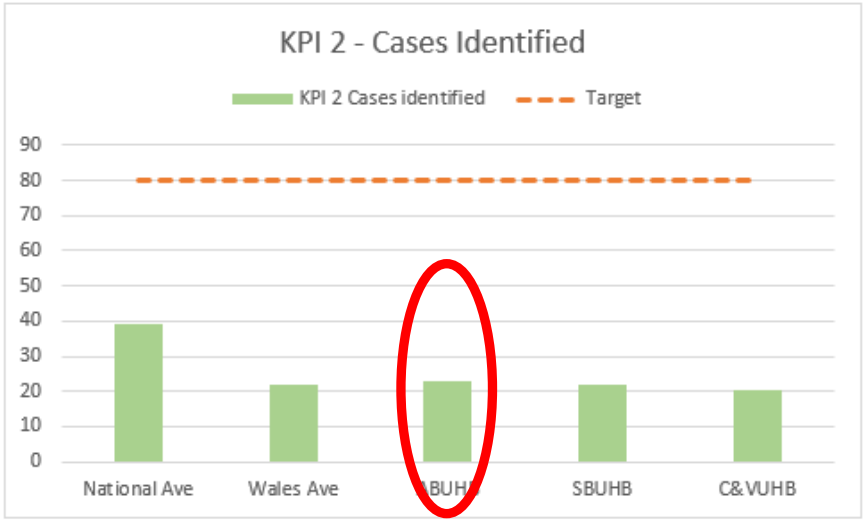
Recommandations for fracture liaison services

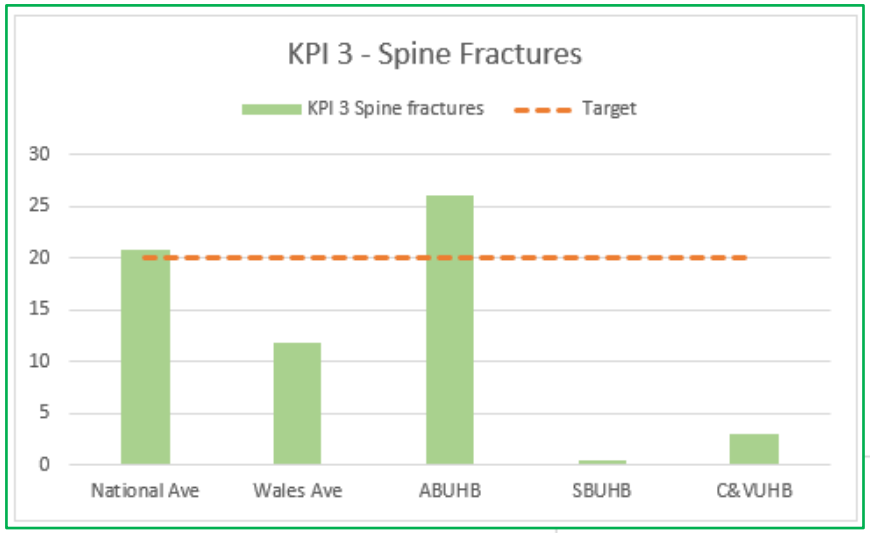
Model – 80/50/80



KPI 2 - All FLSs submitting less than 80% of their expected caseload to the FLS-DB should review the underlying causes for this and agree an action plan to improve identification rates - **ABUHB performing at 22.7%**

KPI 3 - All FLSs should prioritise identifying patients with spine fractures over those with fractures below the knee, given that they have a higher risk of subsequent fractures - **The target is 20% with ABUHB above target at 26.1%**





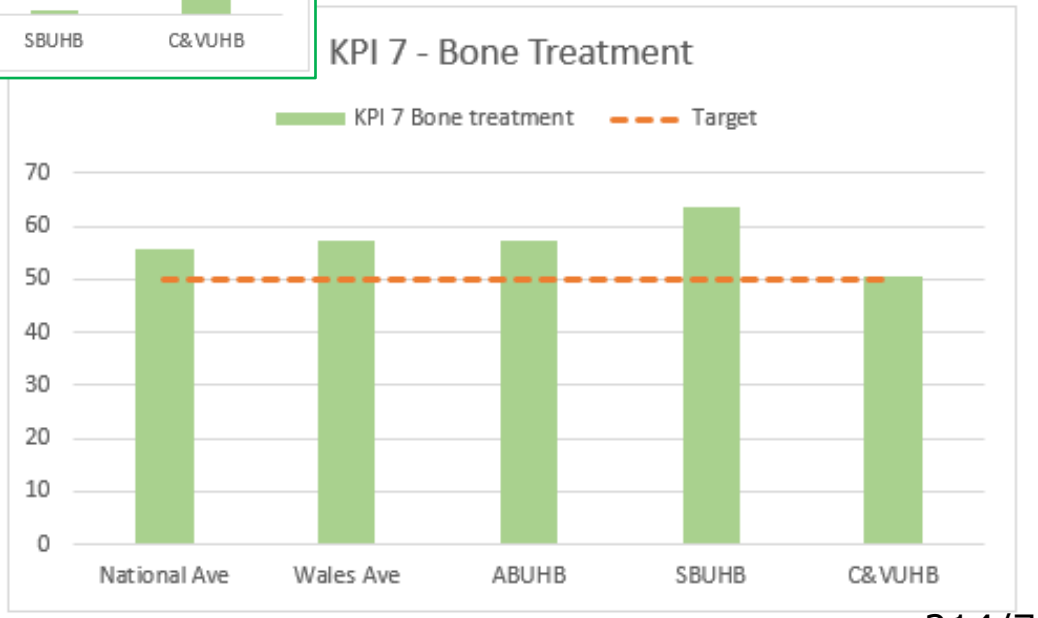
Bone therapy recommended (KPI 7)

More patients were recommended anti-osteoporosis medication in 2021 than in 2019 (56% vs 52%).

Once we identify a fragility fracture, we do commence treatment

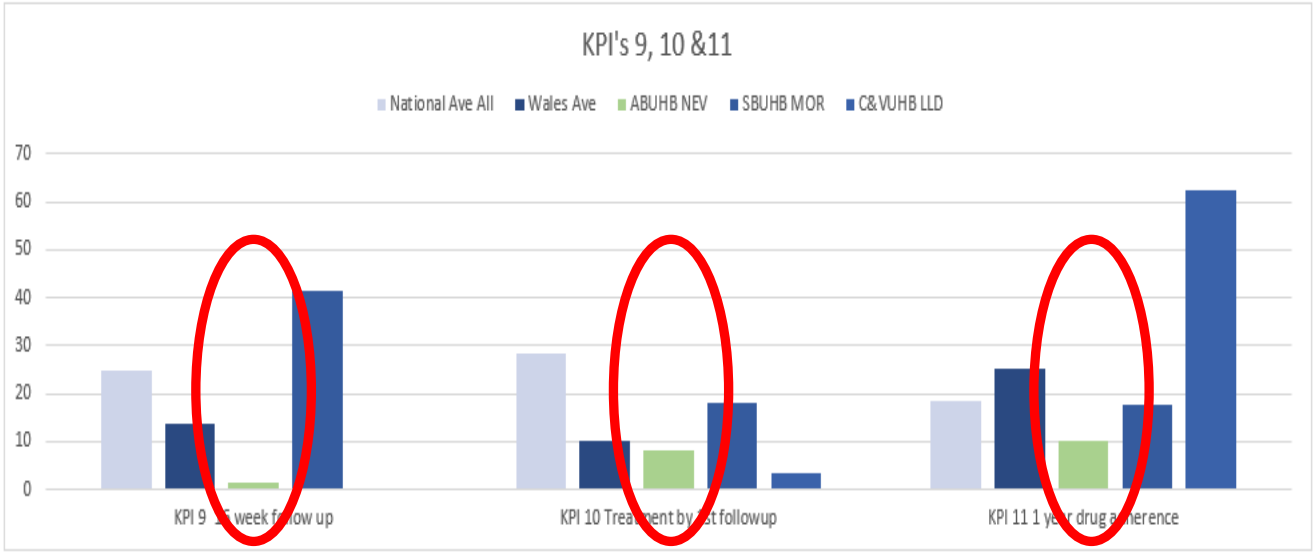
ABUHB is performing at the Welsh average of 57.5%

which is better than the National Average of 55.8%



Monitoring, follow up and adherence (KPIs 9, 10 and 11)

All three KPIs for monitoring and follow up have improved in 2021 in comparison with 2019. For example, the percentage of patients who were followed up within 16 weeks of their fragility fracture has increased from 41% in 2019 to 47% in 2021 – **These performance targets in ABUHB are much lower than the National Average (NA)**

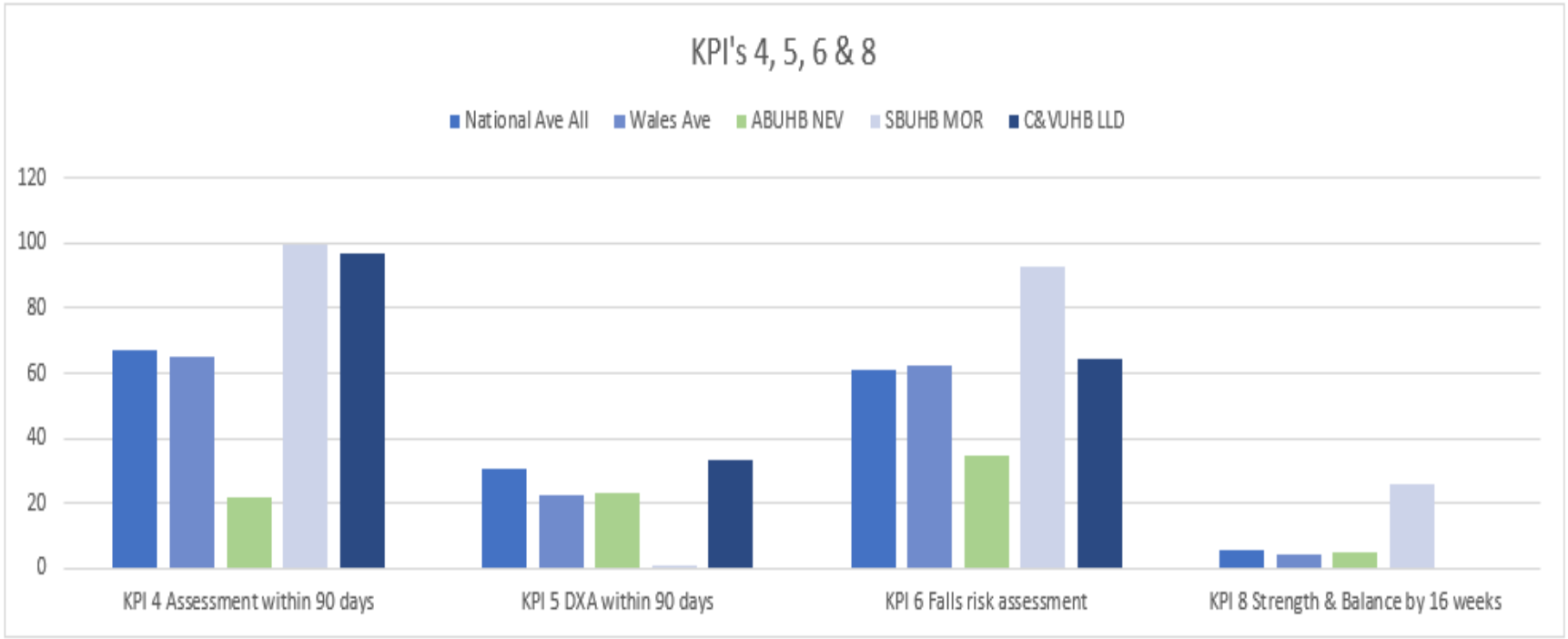


Missed opportunity for ABUHB

- We identified – 22% of patients (n=875) (missed 58% as per rule) – **Expected fragility fractures – ABUHB = 3875**
- We treated 56% - so treated 12% of identified patients
- We reviewed 1.4% patients at 16 weeks = 0.1% patients reviewed at 16 weeks
- We reviewed 10.1% - one year drug adherence = 1.2%

- Missed opportunity = 99%

The report does not concentrate on KPI's 4, 5, 6 & 8 – we are working and improving in these areas



Assurance level	Description	Select	Risk level	Description	Select
Limited	The project did not achieve the standards or criteria being audited against	Yes	Moderate	Repeated failure to meet internal standards/Major patient safety implications if findings are not acted on	Yes
Has this audit been placed on a Risk Register (N/A if above risk is None)					**NO**

Key Success and Concerns

Report Successes:	
1	KPI 3 Spine Fracture - A major improvement was observed both in comparison to the previous and also against the national benchmark for spine fracture improved from 26% to 35% (National average=21%);
2	KPI 7 Bone Treatment - Bone treatment improved from 58% to 66% (National average=54%)
3	FLS-DB showed 42.6% (n=1651) patients identified in the year 2022, Case volume has increased by 88% compared to previous year 2021
4	Process mapping supported the establishment of the two FLS-DB pathways: Rheumatology team to provide care for patients under 75 with the current Clinical Nurse Specialist (CNS) and COTE team to assess all patients above 75 years. Medical Division supported the pilot for 12 months by funding two new CNS. Collaboration with the Radiology assisted to generate separate weekly fracture data for the Rheumatology and COTE teams.
5	Falls assessment improved from 35% to 81% (National average=61%)

Report Concerns:	
1	KPI 2 Cases identified - Only 22.7% (n=879) of patients were identified by the FLS team, Aneurin Bevan University Health Board, Wales in 2021 (National average=40%).
2	KPI 4 Assessment within 90 days
3	KPI 5 DXA within 90 days
4	KPI 6 Falls Risk Assessment
5	KPI 8 Strength and Balance by 16 weeks
6	KPI 9 - 16 weeks Follow Up
7	KPI 10 - Treatment by first Follow Up - ABUHB is catching with 16 weeks Follow up, reached 19% in the year 2022
8	KPI 11 - 1 year drug adherence - with ABUHB, we are not able to review patients at 1 year and currently working to improve for f-ups
9	Cases remains lower than the national recommendation of 50% (currently seeing 43% in ABUHB)
10	Further resource required for CNS/Admin
11	Wider partnership with radiology and T&O and A&E to identify new fragility fractures

Report Recommendations:		Progress:
1	In this year's annual report, the FLS-DB team are encouraging services to focus on KPIs 2 and 3 (identification), KPI 7 (bone therapy recommended) and KPIs 9, 10 and 11 (monitoring, follow-up and adherence) for service improvement goals (80/50/80 model).	All recommendations are being addressed and remain ongoing to improve the Health Board FLS.
2	KPI 2 – Identification (all fragility fractures) - All FLSs submitting less than 80% of their expected caseload5 to the FLS-DB should review the underlying causes for this and agree an action plan to improve identification rates.	
3	KPI 3 – Identification (spine fractures) - All FLSs should prioritise identifying patients with spine fractures over those with fractures below the knee, given that they have a higher risk of subsequent fractures.	
4	KPI 7 – Bone therapy recommended - All FLSs with less than 50% treatment recommendation should review their pathways in line with NICE technology appraisals and guidance (NICE CG146, QS86, TA161, TA204, TA464, TA791), the NOGG 2021 clinical guideline for the prevention and treatment of osteoporosis and the Royal Osteoporosis Society (ROS) clinical standards for FLSs.	
5	KPIs 9, 10 and 11 – monitoring, follow up and adherence - All FLSs should continue to aim for monitoring performance for at least 80% patients who are recommended or referred for therapy. This includes patients who receive injectable therapies after referral to other clinical teams, to ensure the treatment recommendations have been actioned.	
6	To achieve these aims, the FLS-DB audit recommends that: All FLSs should have regular monthly governance meetings that report to their organisation's executive teams and use FLS-DB data in these meetings to prioritise areas for service improvement.	

Report Recommendations:		Progress:
7	To achieve these aims, the FLS-DB audit recommends that: 9 All FLSs should have an active service improvement team that includes at least two patients/ carers and representation from clinicians, administration and management to complete at least one quality improvement cycle every year.	All recommendations are being addressed and remain ongoing to improve the Health Board FLS.
8	To achieve these aims, the FLS-DB audit recommends that: 10 All FLSs should use the regional benchmarking function to develop regional networks that share good practice and drive service improvement.	
9	To achieve these aims, the FLS-DB audit recommends that: 11 All FLSs should engage with the ROS and local decision makers to ensure their FLS is resourced based on local need. The ROS FLS implementation toolkit offers support for the development of services from business case right through to outcomes and performance measurement, including providing an FLS benefits calculation to cost pathways for the local population.	
10	Recommendations for senior executive decision makers ~ 12 All senior executive decision makers should hold a key stakeholder meeting to explore how local needs for fragility fracture patients can be met. Patient representatives and members of the ROS should be invited to the meeting, and it should plan for effective and sustainably resourced FLSs based and designed on the KPIs from the FLS-DB.	
11	Recommendations for senior executive decision makers ~ 13 All senior executive decision makers should ensure FLSs are commissioned to deliver the Best MSK pathway for secondary fracture prevention, participate actively with the FLS-DB mandatory national audit and complete at least one quality improvement cycle per year.	

Local Recommendations:		S.M.A.R.T Actions:	Responsible: Due Date: Progress:
1	To write a business plan to demonstrate the requirements for the Health Board to provide an affective FLS	• Write a business case for CNS support and Admin support for the team and review consultant sessions • We will continue to collaborate with the ROS and ensure that Health Board's focus on the strategic planning for the FLS is delivered • Medical Division is supporting us with the two WTE CNS and have funded and have been supported us to write a business case. The initial results of the pilot have already supported the further extension of the pilot for another year with the aim of drug adherence by engaging with the Community and Primary care teams. This pilot also highlights the importance of improving culture and multi-professional awareness of fragility fractures and FLS.	Complete – FLS Economic Benefits Calculator Report completed and FLS Costing Tool completed by Dr Inder Singh 18/01/2024

Appendix 7

Audit Title:	**National Pregnancy in Diabetes Audit 2021 and 2022 (01 January 2021 to 31 December 2022)** Publication Date:12 Oct 2023	**Clinical Lead:**	**Dr Anurag Pinto – Consultant Paediatrician**
Rationale:	The purpose of the NPID Audit is to report on the demographics, patterns of care and pregnancy outcomes for women with diabetes in England and Wales, and to provide services with information to help improve the quality of care before and during diabetes pregnancies. It measures the effectiveness of diabetes pregnancy healthcare against NICE Clinical Guidelines and NICE Quality Standards. NICE recommends 5mg/day folic acid supplementation for 3 months pre-pregnancy and avoidance of potentially harmful medications. NICE guidelines also recommend targets for pre-pregnancy and antenatal glucose control; and since December 2020 NICE have recommended that women with type 1 diabetes are offered continuous glucose monitoring (CGM) to help them meet their pregnancy glucose targets. The guideline recommendations are based on strong evidence that use of CGM technology improves maternal glucose and reduces obstetric and neonatal complications		
Objectives:	This NPID report focuses on NICE guidance and Quality Standards for the care of diabetes in pregnancy. NICE guidelines emphasise the importance of planning for pregnancy from adolescence for women with diabetes, as part of diabetes education. It advises that women with diabetes use contraception and have monthly measurement of HbA1c, aiming to reach the pregnancy glucose target of HbA1c <48mmol/mol. This is in addition to taking folic acid (5mg/day) and avoiding medications potentially harmful to the foetus or pregnancy (e.g. angiotensin-converting enzyme inhibitors, angiotensin-II receptor antagonists, and statins that are not approved for use during pregnancy). Advice on how to lose weight should be offered to those with a body mass index (BMI) above 27 kg/m2. All pregnant women should be offered immediate contact with a joint diabetes maternity clinic, as soon as possible after confirmation of pregnancy.		
Presented to Clinical Standards and Effectiveness Group – 30th November 2023			

Data is collected of pregnancy outcomes in women with pre-existing diabetes (not gestational diabetes)

This audit has 3 key questions:

1. Were women with diabetes adequately prepared for pregnancy?
2. Were appropriate steps taken during pregnancy to minimise adverse outcomes to the mother?
3. Were adverse neonatal outcomes minimised?



Findings:

1. For the first time T2 women outnumbered T1
2. T2 women accessed service late and had poorer outcomes
3. 7/8 pregnancies started with poor preparation (no improvement in 7 years)
4. HbA1C of <43 in 3rd trimester (new target) improved outcomes greatly
5. First full year of data for Grange University Hospital

Actions from previous year:

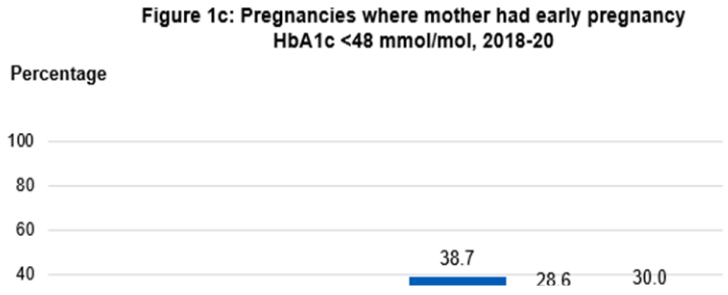
- Joint working with primary care on pre-pregnancy optimisation HbA1c,48 mmol/mol and 5mg Folic Acid (FA)30th November 2023
- Community midwifes early referral with special focus on T2
- Ongoing audit of reasons for pre-term births & SCBU admissions (particularly T2)
- Long-term planning of pregnant women with gestational diabetes and raised BMI (baby steps)

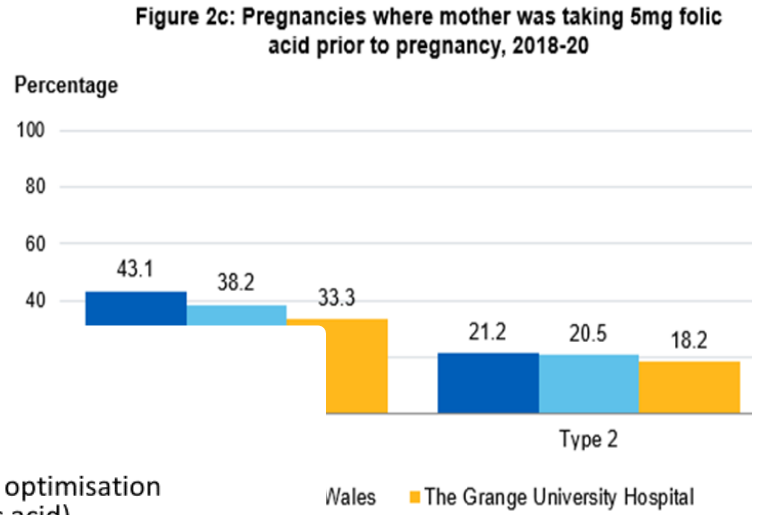
Results:

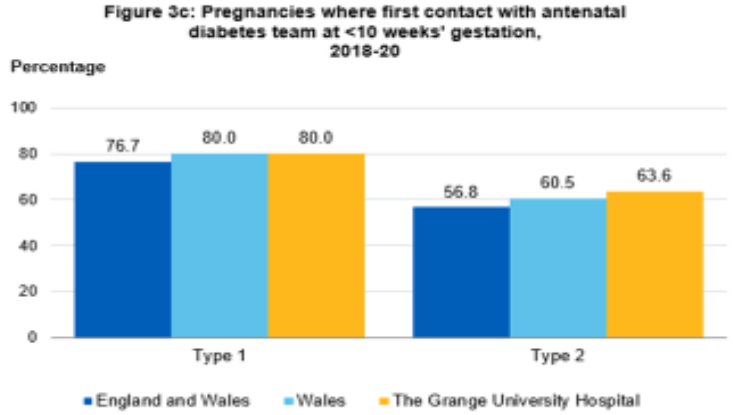
- Lower than expected recoding of FA
- Not as much pre-term (admissions to SCBU) births as expected

The use of BadgerNet will improve data moving forward.

History NPID report 2022 – ABUHB







Action plan- ABUHB

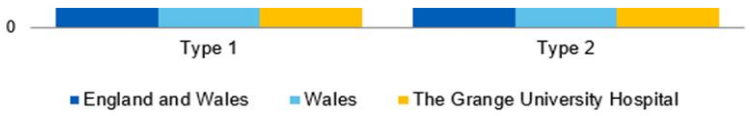
- Jointly work with Primary Care re need for pre-pregnancy optimisation of diabetes (HbA1C <48mmol/mol and being on 5mg Folic acid).

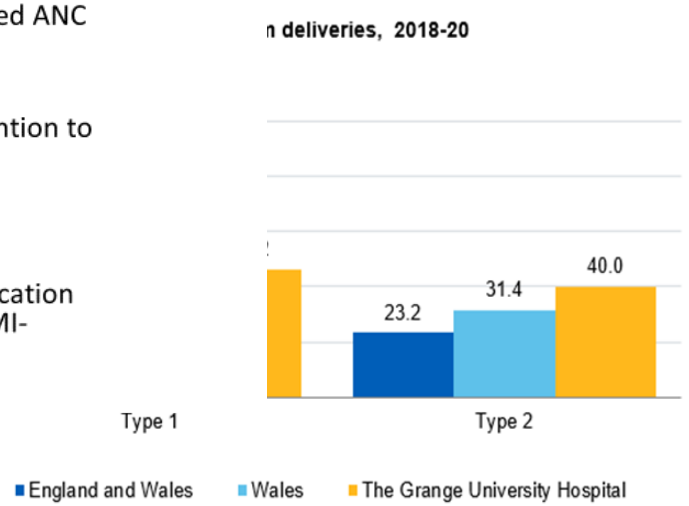
Referral into MANC: T2DM special focus – on early referral to med ANC (Message to community MWs)

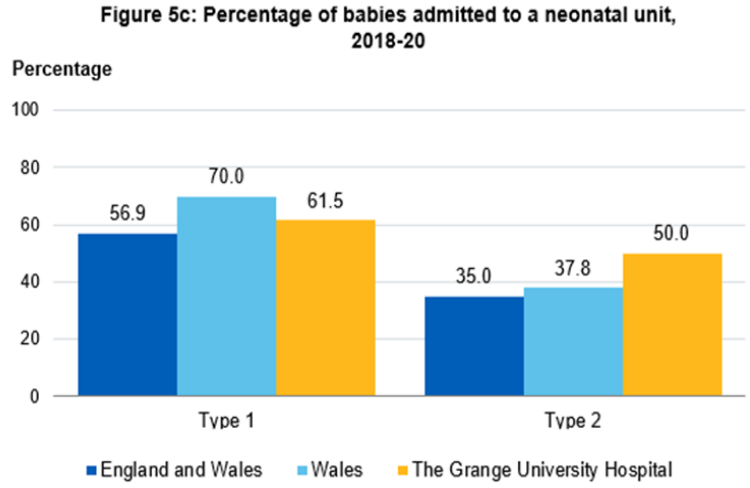
Ongoing Audit of women delivered in 2021- with particular attention to

- Reasons for preterm birth- (particularly in T2DM)
- SCBU admissions (particularly in T2DM)

Long term planning- Good quality Education and lifestyle modification strategies targeted to pregnant women with GDM and raised BMI- Baby steps







Action plan- ABUHB

- Jointly work with Primary Care re need for pre-pregnancy optimisation of diabetes (HbA1C <48mmol/mol and being on 5mg Folic acid).

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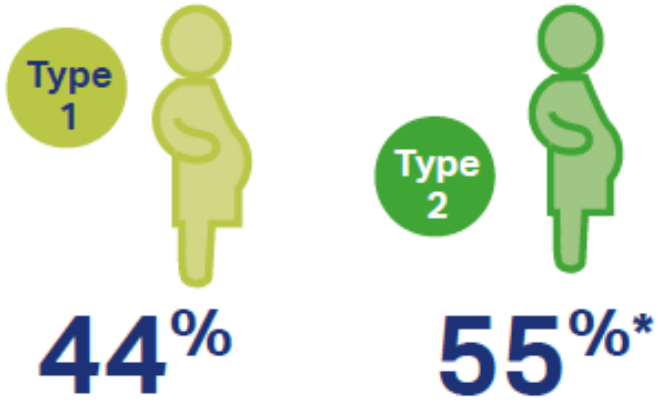
SUMMARY

1. Evidence of Pre-conceptional planning was found in 15 women (20%) of women only.
2. A very small percentage of women had taken pre-conceptional folic acid 5mg (16%). This may be because of not clearly documenting the timing of starting 5mg of FA.(all started 5mg after 1st contact)
3. 84% had at least 2 antenatal HbA1c checks (soon after booking pregnancy and in 3rd trimester) . 70% of women who had Hba1c >86 at booking had adverse pregnancy outcomes.
4. 85% of women had AN FU as per NICE GL and 91% of women had scans as per NICE GL there was congruency in US and birth weight in 80% of the women
5. 79% of steroids were given in the optimal time frame (24hrs to <7 days)
6. 73% Of women had live births, out of which 38% were preterm deliveries
7. 25 women (45%) opted for VB and 30 (55%) women opted for planned CS.
   52% of planned vaginal births and 67% of planned caesarian births were successful.
   CSR for this group= 76%
8. 25% of livebirths required SCBU/ NICU. 15 (27%) macrosomia and 3 (5%) hypoglycaemia

National Pregnancy in Diabetes Audit 2021and 2022, England and Wales*

* This audit does not include pregnancies in women with gestational diabetes (diabetes that develops in pregnancy)

Pregnant women with diabetes in 2021 and 2022



* 1% of pregnant women with diabetes had other rarer forms of diabetes such as MODY (Maturity Onset Diabetes of the Young) and LADA (Latent Autoimmune Diabetes in Adults) or unspecified diabetes

Pregnant women with **type 2 diabetes** are more likely than those with type 1 to be:



and to experience **health inequalities** before and during pregnancy. This finding is unchanged since 2014.

95% of women with type 1 diabetes wore **continuous glucose monitors** in 2022*



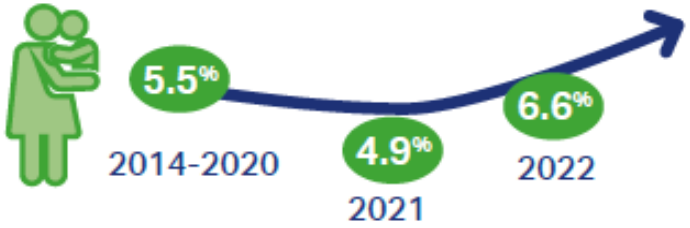
improving:

glucose levels for mothers

outcomes for women and babies

* Accurate data on CGM use has only been available since 2022

Rates of **serious outcomes** for women with **type 2** diabetes and their babies increased in 2022*



* Serious outcomes include miscarriage, stillbirth or neonatal death, or birth defect. It's important to remember that these outcomes are rare and there are many things you can do to reduce the risk

Aneurin Bevan University Health Board results: Combined T1 & T2

Type 1 cohort	Type 2 cohort	Total
30 Cohort total	20 Cohort total	50 Cohort total

<50% capture rate

Please note the cohort number for Type 2 is too low calculate therefore figures below include both T1 and T2 for the Health Board.

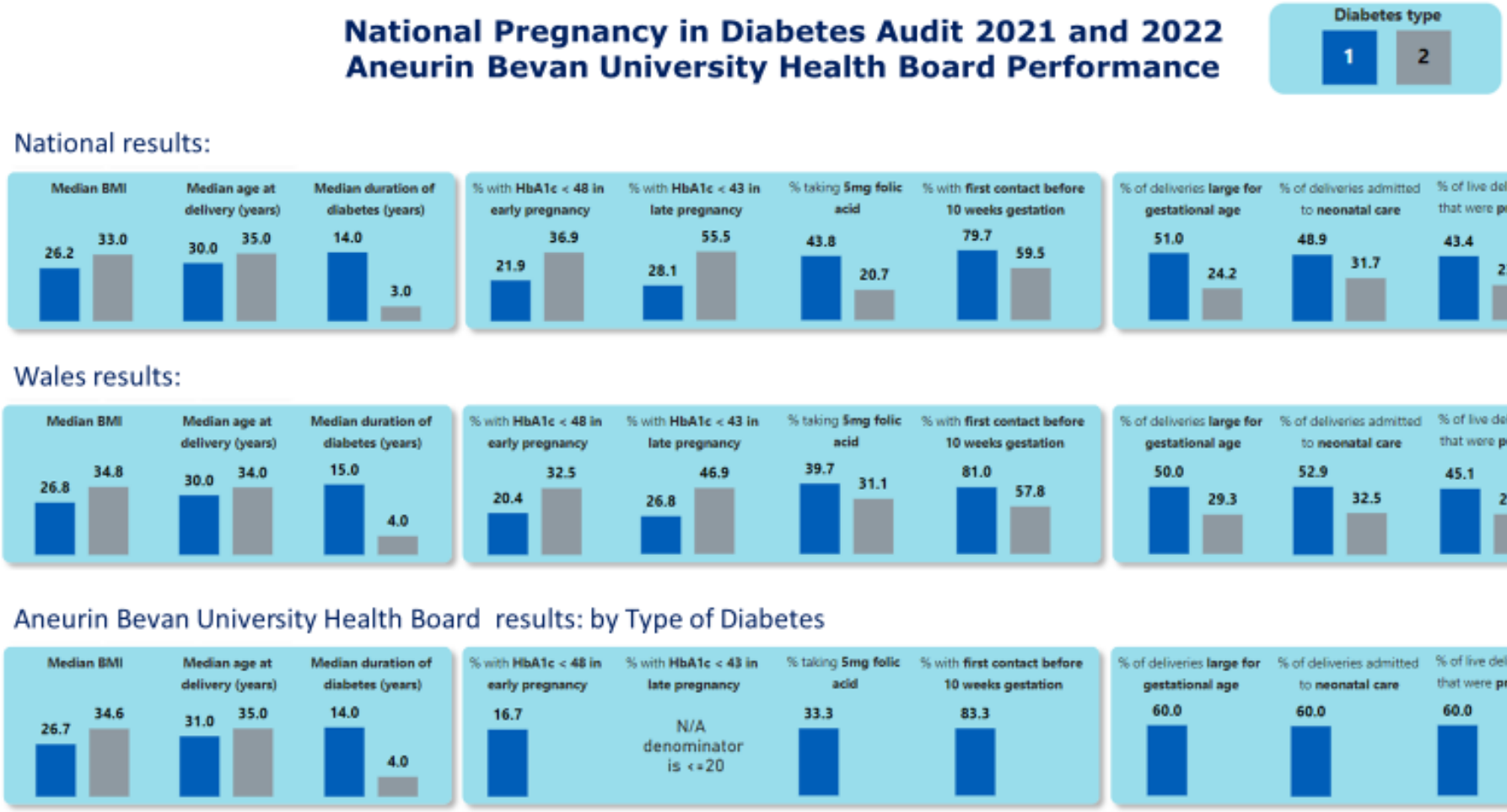
Median BMI	Median age at delivery (years)	Median duration of diabetes (years)	% with HbA1c < 48 in early pregnancy	% with HbA1c < 43 in late pregnancy	% taking 5mg folic acid	% with first contact before 10 weeks gestation	% of deliveries large for gestational age	% of deliveries admitted to neonatal care	% of live deliveries that were preterm
29.9	32.0	9.0	22.2	33.3	30.0	80.0	55.6	62.5	50.0

Charts below show the percentage composition of the women in the service, broken down by the variable/measure shown in the chart title. Percentages may not sum to 100 due to rounding.



NPID 2023 report demonstrate higher levels of T2 due to manifesting earlier in age, higher rates in more deprived areas and ethnic minorities having more serious outcomes. T1 women with Continuous Glucose Monitoring (CGM) has more improved outcomes. The Health Board had 50 cases however only capturing 50% of the data relating to use of FA, HbA1c <48 in 1st and 3rd trimesters.

National Pregnancy in Diabetes Audit 2021 and 2022
Aneurin Bevan University Health Board Performance



Differences in the practice of checking HbA1C –
at NHH (in 2022)1/3rd had HbA1C <48 in 1st trimester

Late pregnancy HbA1C- (2022)-
75%& 27% had <48 and 42%&20%<43mmoml/mol

67% taking 5mg FA pre pregnancy don't have this info for both sites- and 100% from 1st contact in both sites

Measures relating to Hba1c,48 in early pregnancy and Hba1c <43 in late pregnancy, folic acid and first contact within before 10 weeks gestation, the report had no data for the Health Board however Dr Pinto has analysed the data and there is a variation between the sites, NHH HbA1c <48 – one third in 1st trimester. For 2022 late pregnancy HbA1c <48 75% and <43 42% and 67% taking 5mg FA pre pregnancy don't have this info for both sites- and 100% from 1st contact in both sites. Data capture needs to be improved going forward.

Measures are also relating to Large for gestational age, admission to neonatal and live pre-term births.

Assurance and Risk

Assurance level	Description	Select
Significant	The project has mostly achieved the standards or criteria being audited against	Yes
Risk level	**Description**	**Select**
None	Standards met and findings demonstrate no risk to patient safety	Yes
Has this audit been placed on a Risk Register (N/A if above risk is None)		**NO**

Successes and Concerns

Report Successes:	
1	All women are using the FreeStyle Libre System Dexcom
2	Above national average for early contact in T1DM
3	Local audit shows better early and 3rd trimester HbA1C and outcomes for babies (reassurance)
4	Working with Peri-prem Cymru national project to reduce morbidity in pre-term births

Report Concerns:	
1	Data collection and feeding into NPID
2	Variation in practice across Health Board sites
3	Higher levels of Preterm birth in ABUHB population
4	Improve checks on HbA1c in early and late pregnancy

Reported Recommendations:		Health Board Performance
1	Welsh Health Boards should help to further improve pregnancy outcomes by ensuring that diabetes care providers enable all women with type 1 diabetes of reproductive age to access diabetes technology (continuous glucose monitoring and hybrid closed-loop systems) to achieve their pregnancy glucose targets.	We use FSL pr Dexcom routinely in pregnant women with T1DM
2	Welsh Health Boards should ensure that providers of maternity diabetes care improve glucose lowering using culturally appropriate dietary support, glucose monitoring and intensive insulin therapy to reduce the adverse trend of serious adverse pregnancy outcomes in women with early-onset type 2 diabetes.	Consistently checking HbA1C early and in late pregnancy , aiming for TIR to >70% (>90%)
3	Welsh Health Boards should ensure that aiming for target glucose control (HbA1c<48mmol/mol) remains an imperative in women with diabetes. They should further ensure that women with diabetes have access to effective methods of contraception to prevent unplanned pregnancy. Those planning pregnancy should be offered monthly HbA1c checks, 5mg folic acid supplementation, medications review, weight management programmes, and rapid referral to specialist care when pregnancy is confirmed.	A consistent finding of NPID audit is that 7/8 pregnancies are conceived without optimising diabetes

SMART Actions linked to the above REPORT recommendations:				
Rec/Con No.	**Action No:**		**Responsible:**	**Due date:**
Concern 3	1	To investigate the high level of preterm births in the Health Board	Mrs Pinto	31/03/2024
Concern 2	2	Currently updating internal guidance to incorporate New NPID guidance	Mrs Pinto	31/03/2024
	3	Improve cross site working to reduce variation (aspiring to involve Primary Care)	Mrs Pinto	31/03/2024
Concern 1	4	Link with QPS support to ensure accurate data and maximise the volume entered	Mrs Pinto	31/03/2024

Results from Actions	
1	We have completed an audit (data presented in December CG meeting) and we do have higher preterm births. Our next step is to work upstream and find ways to prevent preterm births. Responsibility to oversee this lies with our clinical leads (Gareth Edwards- CD, Jyothi Singh - Obstetric lead, Jayne Beasley- Head of Midwifery)
2	GL updated - submitted to CEF team for ratification- Jan 2024
3	1st meeting has taken place, further quarterly meetings planned
4	Dr A Pinto working with QPS Team - Data for 2023 is being entered into NPID database Jan/Feb 2024

Appendix 8

Audit Title:	National Diabetes Audit 2021-22, Type 1 Diabetes Published 12th October 2023	Clinical Lead:	Dr Fiona Smeeton Consultant in Medicine
Rationale:	This NDA report focusses on NICE guidance and Quality Standards for the routine care of people with type 1 diabetes. Everyone with diabetes should be reviewed at least once a year. Having diabetes can lead to health complications such as blindness, kidney failure, heart disease, stroke and premature death. The review should include blood tests for HbA1c (glucose control), creatinine (kidney function), cholesterol (heart risk), a urine test for albumin (kidney risk), measurements of blood pressure and weight, examination of the feet (foot ulcer risk) and review of smoking habit. These are called the 8 care processes. Retinal screening run by dedicated screening programmes, is the ninth care process. At review, treatment should be adjusted where necessary to achieve NICE recommended HbA1c and blood pressure levels; also, those with high heart risk should be prescribed a statin. These are known as the 3 treatment targets. NICE also has guidance for the use of Continuous Subcutaneous Insulin Infusion (Insulin Pumps) and Continuous Glucose Monitoring Systems (CGMS) .		
Objectives:	Measurements of routine diabetes care for people with type 1 diabetes are reported in the publicly available quarterly dashboard (England GP record extracts only, for all ages: NDA England primary care quarterly dashboard), the annual care processes and treatment targets dashboard (GP record extracts plus data submitted by specialist services: NDA Core annual dashboard - England and Wales) and the NDA Type 1 dashboard - England and Wales (using the cohort validated with prescription data and including data on CGMS and pumps). Data are published at national, regional, integrated care board (ICB), sub ICB, local health board (LHB) and specialist service levels (all dashboards), and at primary care network (PCN) and practice levels (quarterly and core dashboards only).		
Presented to Clinical Standards and Effectiveness Group – 30th November 2023			

National Type 1 Diabetes Audit 2021-22, England and Wales

NATIONAL DIABETES AUDIT

Type 1 diabetes is a serious condition where your blood glucose (sugar) level is too high because your body can't make a hormone called insulin.

227,435 adults in England and Wales have a diagnosis of type 1 diabetes.
This report covers the period 1 January 2021 to 31 March 2022.

Having diabetes can lead to health complications such as blindness, kidney failure, heart disease and stroke. It is essential that everyone with diabetes receives certain healthcare checks every year.

The results of the checks can show whether someone is at risk of developing health complications.

Treatment should be adjusted where needed to achieve recommended HbA1c (average blood glucose) and blood pressure levels. Those with high heart risk should be prescribed a statin. These are known as the three treatment targets. Improvements are needed so all people receive the care that they need.

DIABETES UK KNOW DIABETES. FIGHT DIABETES. HQIP NHS England

Findings

Type 1



28 → 33% ↑ ✓

Since 2019-20 achievement of **blood glucose targets** has **improved**

Type 1



50%

of people in England were using wearable **glucose monitors** by March 2022*

Type 1



73 → 70% ↓ ✗

Since 2019–20 achievement of **blood pressure targets** has **declined**

Type 1



Care, treatment and outcomes are dependent on **geography**, **age**, **ethnicity** and **deprivation**

*Data on wearable glucose monitors are not currently available for Wales

Find out more

1. National Type 1 Diabetes Audit

SCAN ME

2. Audit results for your local services
National Diabetes Audit dashboards

The Health Board has the highest severely obese level across Wales at 9.4% and Obese level at 14.3% compared the lowest rate of 9.4% and the 2nd highest deprivation rate across Wales with 43.2% in the most deprived area.

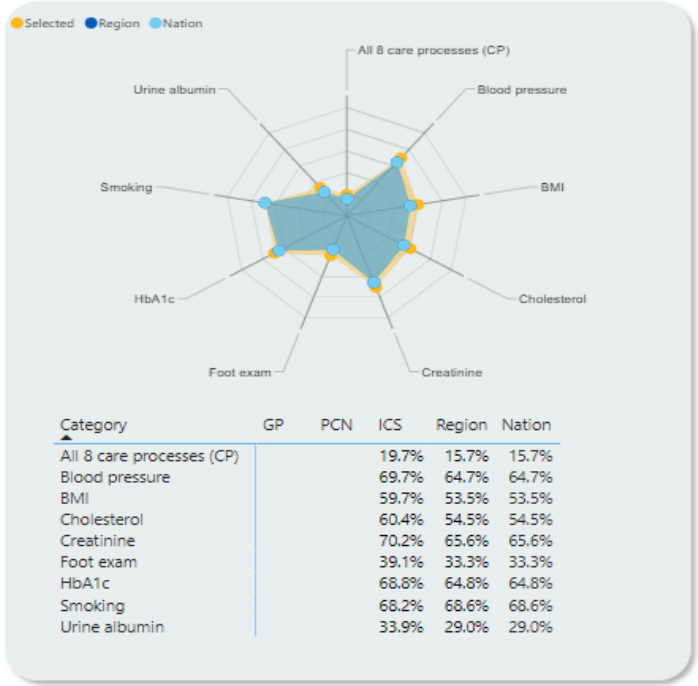
Wales

BMI group - Severely obese

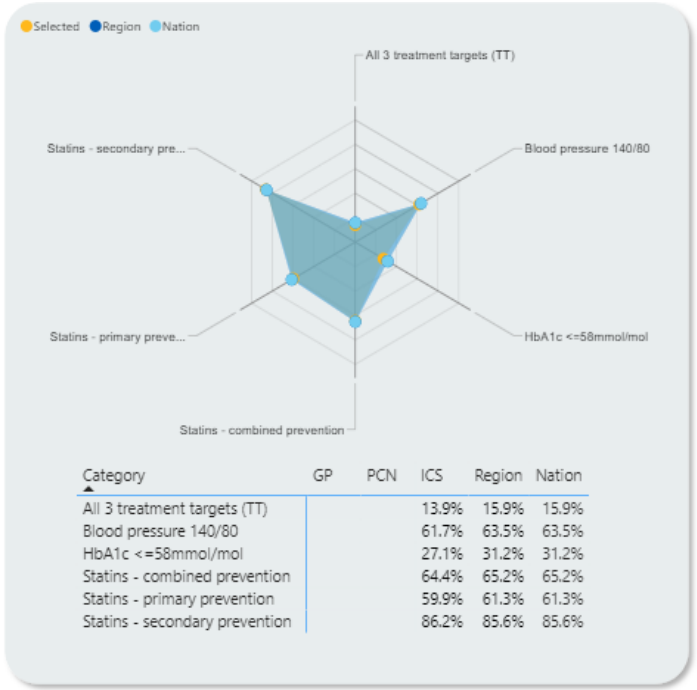
Sub-ICB/LHB	Breakdown	%
Aneurin Bevan ULHB	Severely obese	9.4%
Betsi Cadwaladr ULHB	Severely obese	6.2%
Cardiff & Vale ULHB	Severely obese	6.6%
Cwm Taf Morgannwg ULHB	Severely obese	8.9%
Hywel Dda ULHB	Severely obese	5.4%
Powys Teaching LHB	Severely obese	6.3%
Swansea Bay ULHB	Severely obese	5.3%

The Health Board's most deprived areas are underperforming compared the least deprived areas for CP's however TT's are more varied across the Neighbourhood Care Networks (NCN's).

Aneurin Bevan ULHB	Most deprived	43.2%
Betsi Cadwaladr ULHB	Most deprived	24.2%
Cardiff & Vale ULHB	Most deprived	32.7%
Cwm Taf Morgannwg ULHB	Most deprived	55.0%
Hywel Dda ULHB	Most deprived	20.7%
Powys Teaching LHB	Most deprived	15.3%
Swansea Bay ULHB	Most deprived	39.8%



Category	GP	PCN	ICS	Region	Nation
All 8 care processes (CP)			19.7%	15.7%	15.7%
Blood pressure			69.7%	64.7%	64.7%
BMI			59.7%	53.5%	53.5%
Cholesterol			60.4%	54.5%	54.5%
Creatinine			70.2%	65.6%	65.6%
Foot exam			39.1%	33.3%	33.3%
HbA1c			68.8%	64.8%	64.8%
Smoking			68.2%	68.6%	68.6%
Urine albumin			33.9%	29.0%	29.0%



Category	GP	PCN	ICS	Region	Nation
All 3 treatment targets (TT)			13.9%	15.9%	15.9%
Blood pressure 140/80			61.7%	63.5%	63.5%
HbA1c <=58mmol/mol			27.1%	31.2%	31.2%
Statins - combined prevention			64.4%	65.2%	65.2%
Statins - primary prevention			59.9%	61.3%	61.3%
Statins - secondary prevention			86.2%	85.6%	85.6%

Type 1 Diabetes (T1) the Health Board is 3rd in Wales for All 8 Care Processes (CP) being achieved with 19.7% and the least performing Health Board in terms of all 3 Treatment Targets (TT) at 13.9%. In comparison the English average is 35.2% CP and 22.4% for TT. Wales and the Health Board are behind the National average (NA) rates in both areas.

Blood glucose targets have improved since 2019-2020, with the Health Board achieving the highest levels in Wales.

Glucose Monitoring for the Health Board and across Wales is poor compared to the rates in England. Funding has not been granted for technologies needed, numbers are very low across Wales compared to England.

Blood pressure targets had declined and across Wales performance is lower than England, however the Health Board is the best performing in Wales.

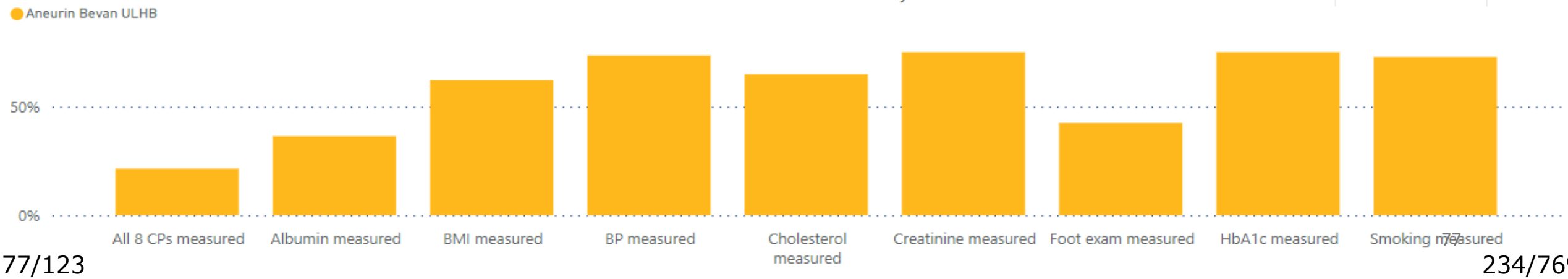
Care Processes and Treatment demonstrate similar patterns across England and Wales and for the Health Board.

Wales | Insulin regimen - Insulin pump

Sub-ICB/LHB	Breakdown	%
Cwm Taf Morgannwg ULHB	Insulin pump	34.1%
Hywel Dda ULHB	Insulin pump	22.2%
Swansea Bay ULHB	Insulin pump	20.6%
Cardiff & Vale ULHB	Insulin pump	17.9%
Powys Teaching LHB	Insulin pump	15.3%
Aneurin Bevan ULHB	Insulin pump	11.2%
Betsi Cadwaladr ULHB	Insulin pump	7.9%

Wales | HbA1c measured - HbA1c measured

Sub-ICB/LHB	Breakdown	%
Powys Teaching LHB	HbA1c measured	81.1%
Aneurin Bevan ULHB	HbA1c measured	75.1%
Cardiff & Vale ULHB	HbA1c measured	75.0%
Betsi Cadwaladr ULHB	HbA1c measured	72.3%
Hywel Dda ULHB	HbA1c measured	70.7%
Cwm Taf Morgannwg ULHB	HbA1c measured	66.3%
Swansea Bay ULHB	HbA1c measured	57.0%



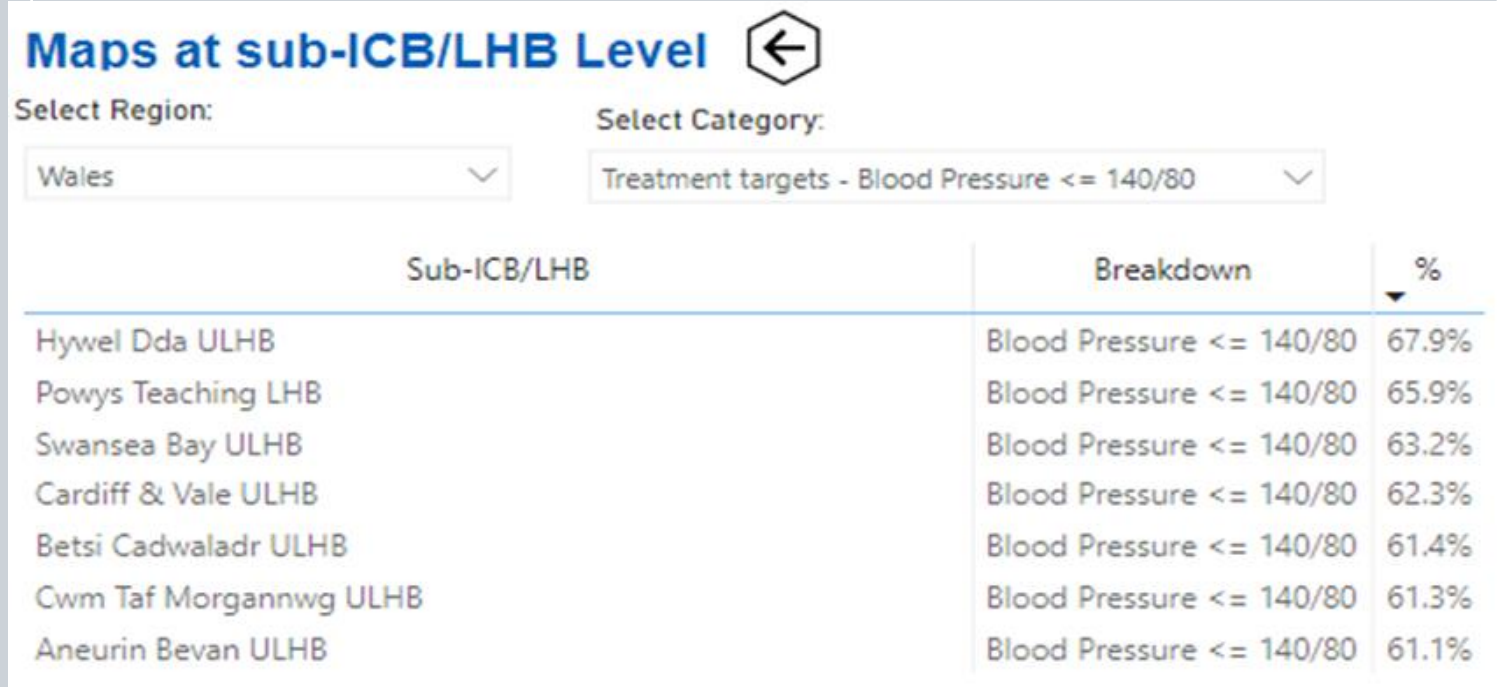
Assurance and Risk

Assurance level	Description	Select
Significant	The project has mostly achieved the standards or criteria being audited against	Yes
Risk level	**Description**	**Select**
None	Standards met and findings demonstrate no risk to patient safety	Yes
Has this audit been placed on a Risk Register (N/A if above risk is None)		**NO**

Successes and Concerns

Report Successes:	
1	Managed to maintain an increasing provision of insulin pump therapy despite not being provided with funding with the business case but this has reached capacity now and is unsustainable.

Report Concerns:	
1	Business case approved and but unfunded in 2022, the new NICE TAG states everyone with type 1 diabetes and with an HbA1c of around 58% despite optimal management should be offered insulin pump therapy. Extrapolating from this audit that equates to around 2200 of the Health Board 2470 type 1, accepting pumps not suitable for all. An estimation of need is between 1200-1500 eligible with our original business case targeted at 600 over 5 years.

Reported Recommendations:		Health Board Performance
1	Commissioners of care should ensure that type 1 diabetes services have the capacity and capability to support all those who can benefit from appropriate glucose technologies and return blood pressure management to pre-pandemic levels.	
2	In Wales, local health boards should support their providers of type 1 diabetes care to reduce apparent inequalities in use of insulin pumps.	Closed Loop System (CLS) & continuous glucose monitor (CGM) levels poor across Wales and the Health Board – not data Action: to secure funding detailed in the approved business case
3	Commissioners of care should ensure that everyone with type 1 diabetes has access to a specialist service.	

Sub-ICB/LHB	Breakdown	%
Hywel Dda ULHB	Blood Pressure <= 140/80	67.9%
Powys Teaching LHB	Blood Pressure <= 140/80	65.9%
Swansea Bay ULHB	Blood Pressure <= 140/80	63.2%
Cardiff & Vale ULHB	Blood Pressure <= 140/80	62.3%
Betsi Cadwaladr ULHB	Blood Pressure <= 140/80	61.4%
Cwm Taf Morgannwg ULHB	Blood Pressure <= 140/80	61.3%
Aneurin Bevan ULHB	Blood Pressure <= 140/80	61.1%

Appendix 9

Audit Title:	National Diabetes Audit: Care Processes and Treatment Targets 2021-22 (Primary Care) Published 12th October 2023 with update 14th December 2023	Clinical Lead:	Dr Clifford Jones & Dr Heather Griffiths

Rationale:

This NDA report focuses on NICE guidelines and Quality Standards for the routine care of people with type 1 and type 2 diabetes . Everyone with diabetes should be reviewed at least once a year. The review should include the following 8 care processes:

> blood tests for HbA1c (glucose control)
> cholesterol (heart risk)
> blood pressure measurement
> examination of the feet (foot ulcer risk)
> creatinine (kidney function)
> urine test for albumin (kidney risk)
> weight measurement (body mass index; BMI)
> review of smoking habit

The ninth care process is retinal screening, which is run by dedicated screening programmes .
At review, treatment should be adjusted where necessary to achieve the 3 NICE recommended treatment targets:
> HbA1c level ≤ 58 mmol/mol
> blood pressure level ≤ 140/80
> those with high heart risk should be prescribed a statin

Objectives:

The NDA supports delivery of high-quality diabetes care by enabling NHS services and organisations to:
> assess local practice against NICE guidelines
> compare their care processes, and care outcomes, with similar services and organisations
> identify gaps or shortfalls that are priorities for improvement
> track responses to change programmes
> identify and share best practice
> provide a comprehensive national picture of diabetes care and outcomes in England and in Wales

Presented to Clinical Standards and Effectiveness Group – 30th November 2023 – Update given 21st March 2024

National Diabetes Audit Core Report 1: Care Processes and Treatment Targets 2021-22,

This data release includes the care process and treatment target measurements for the full 2021-22 audit period (1 January 2021 – 31 March 2022); presented for Wales and Aneurin Bevan University Health Board Primary Care Providers

NATIONAL DIABETES AUDIT

In Wales **16,090** adults had type 1 diabetes and **191,205** had type 2 and other diabetes in 2021-22. The number of people with type 1 and type 2 diabetes have increased since 2017-18.

Diabetes is a serious condition. When you've got type 1 diabetes, you can't make insulin. If you've got type 2 diabetes you have some insulin but either you can't produce enough or it doesn't work effectively.

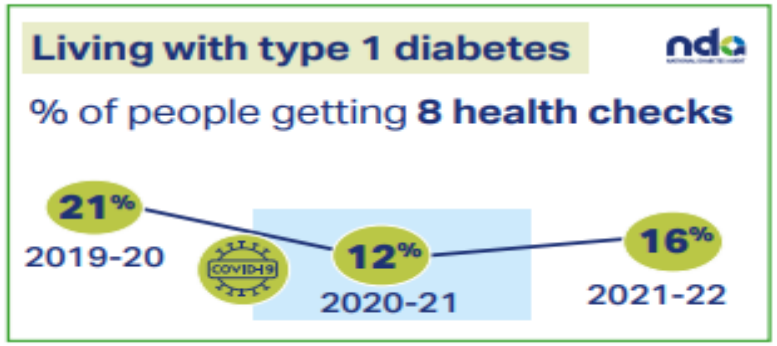
Diabetes can lead to health complications such as blindness, kidney failure and heart disease. But these complications can be prevented.

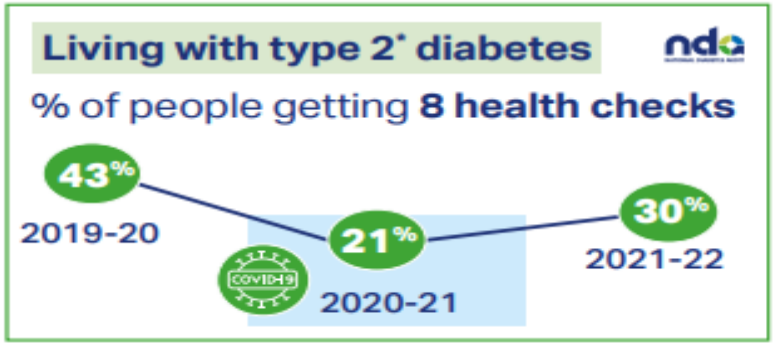
Everyone with diabetes should have healthcare checks at least once a year. Treatments may be adjusted to achieve recommended targets for HbA1c and blood pressure. Those with high heart risk should be prescribed a statin.

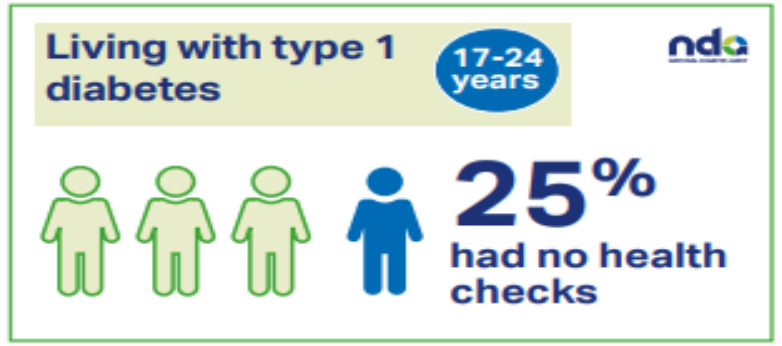
Completing all health checks and achieving the three treatment targets are the key to preventing complications.

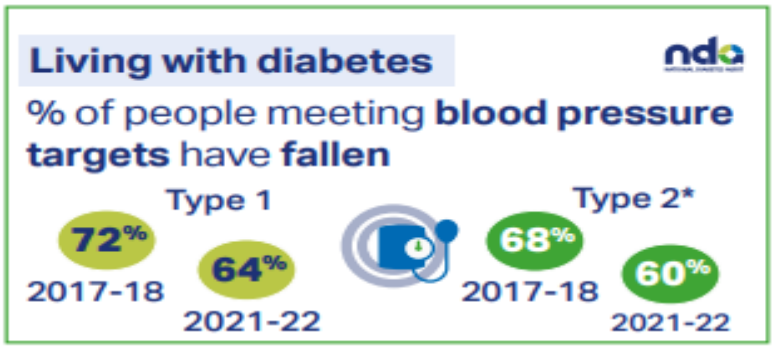
DIABETES UK KNOW DIABETES. FIGHT DIABETES. HQIP NHS England

Findings









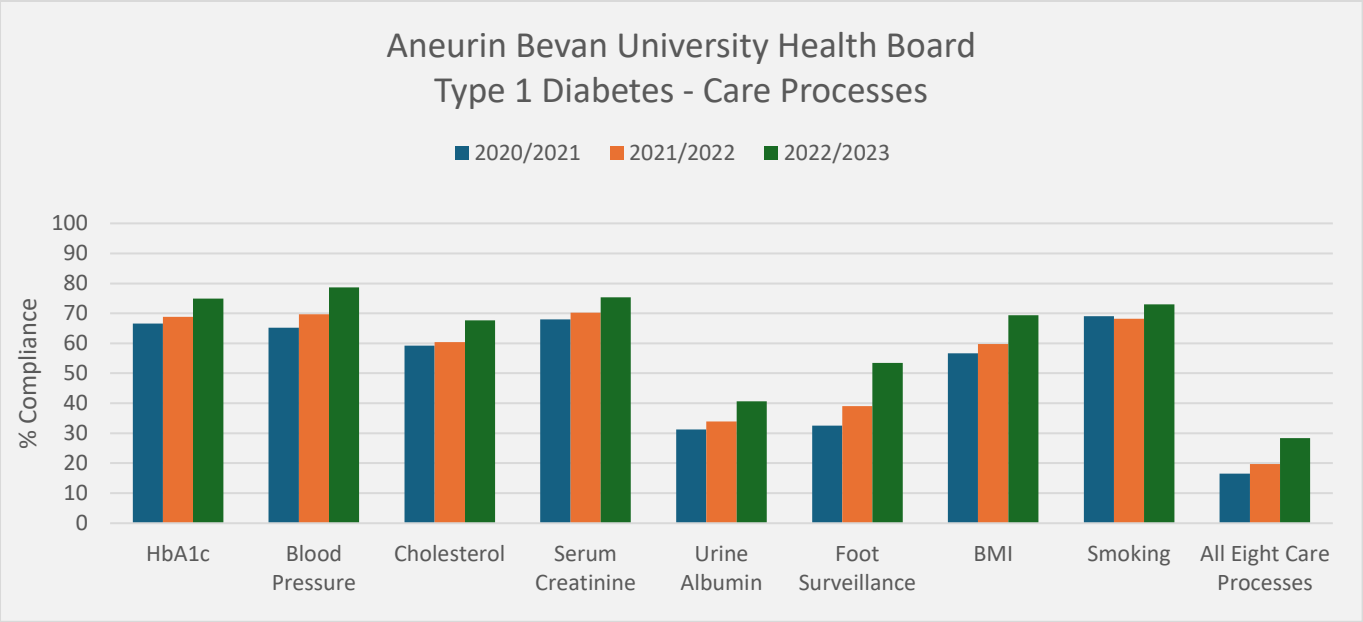
* For this report type 2 diabetes refers to those with a diagnosis of type 2 diabetes and other rarer forms of diabetes such as MODY (Maturity Onset Diabetes of the Young) and LADA (Latent Autoimmune Diabetes in Adults) or unspecified diabetes

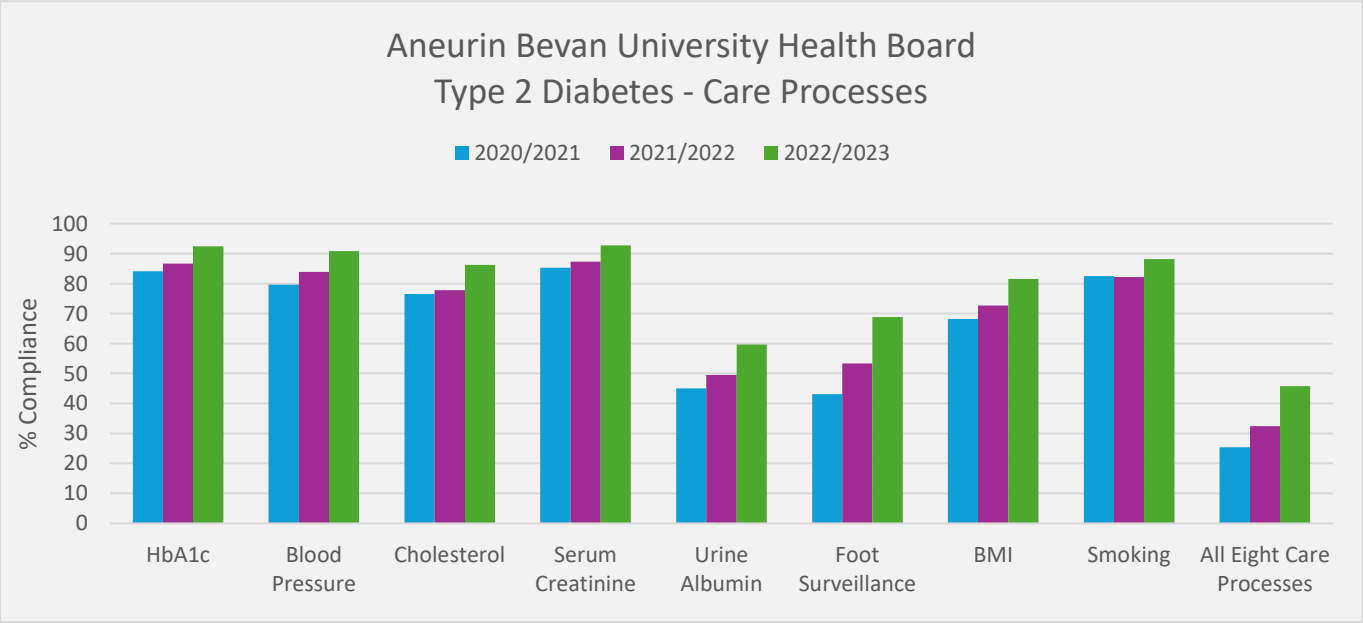
Find out more

1. National Diabetes Audit

SCAN ME

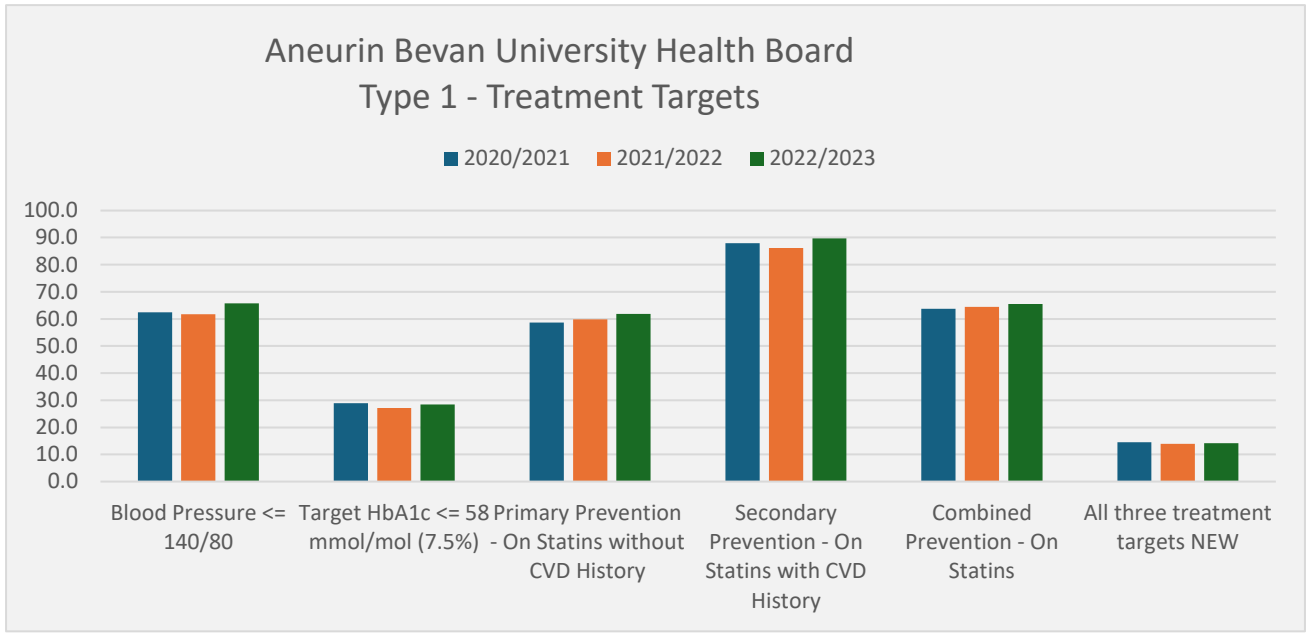
2. Audit results for your local services
National Diabetes Audit dashboards

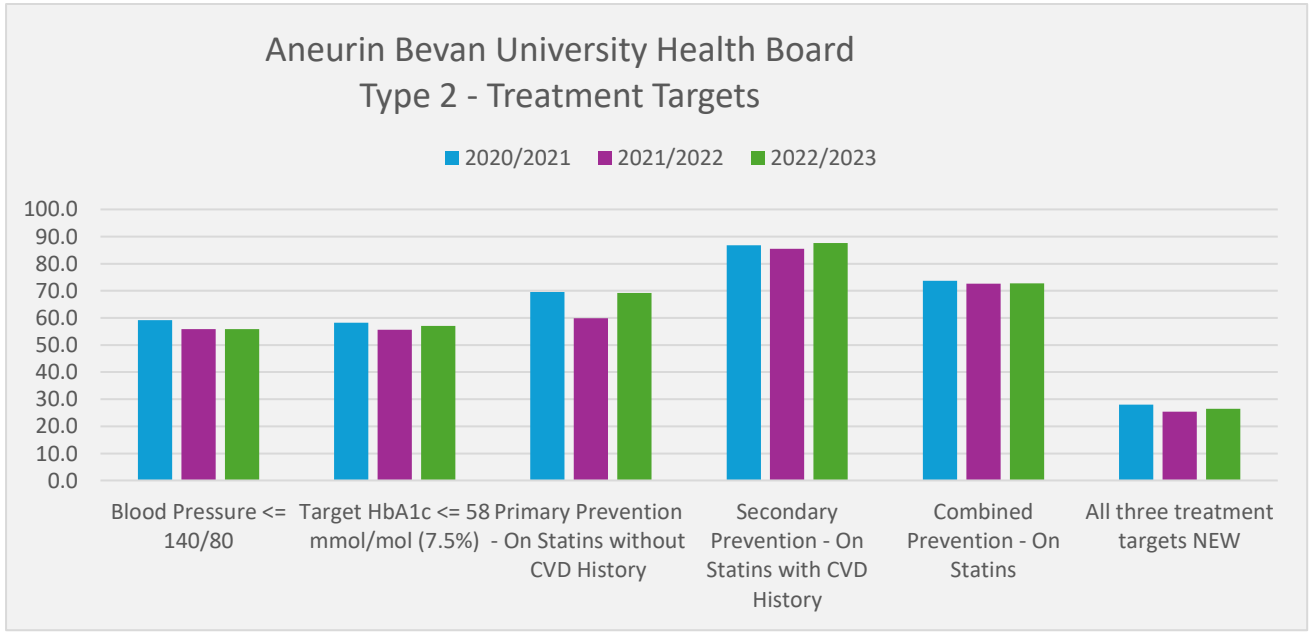




Care Processes

The recommendations required services across the UK to work to return to pre-pandemic levels of care. The Health Boards Care Processes for all eight measures shows an improvement each of the 3 years, and for all eight combined, for both Type 1 and Type 2 Diabetes.



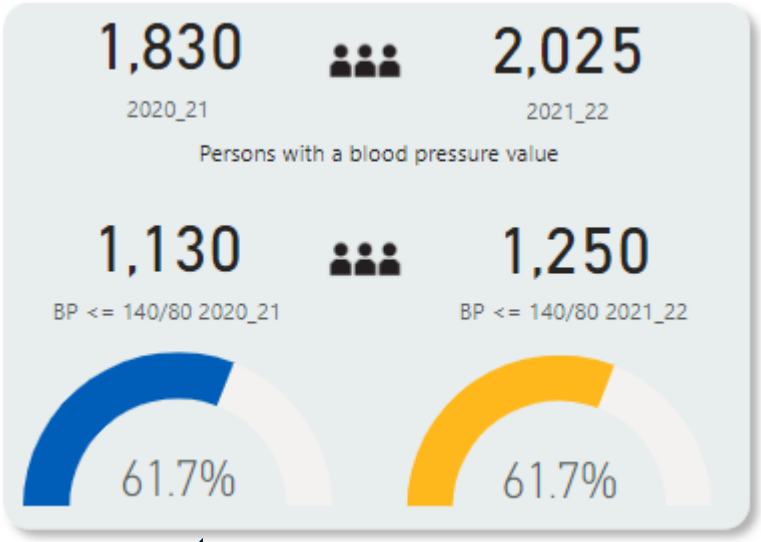


Treatment Targets

For patient with Type diabetes receiving the relevant treatment targets, there was a slight dip in performance during 2021/2022 compared to 2020/2021, however there was an improvement in all other than the HbA1c measure which remained almost level to the 2020/2021 measure.

For patients with Type 2 diabetes, all measures reduced from 2020/2021 to 2021/2022, and only Secondary Prevention on statins increased from 2020/2021. All other measures performance was lesser each year.

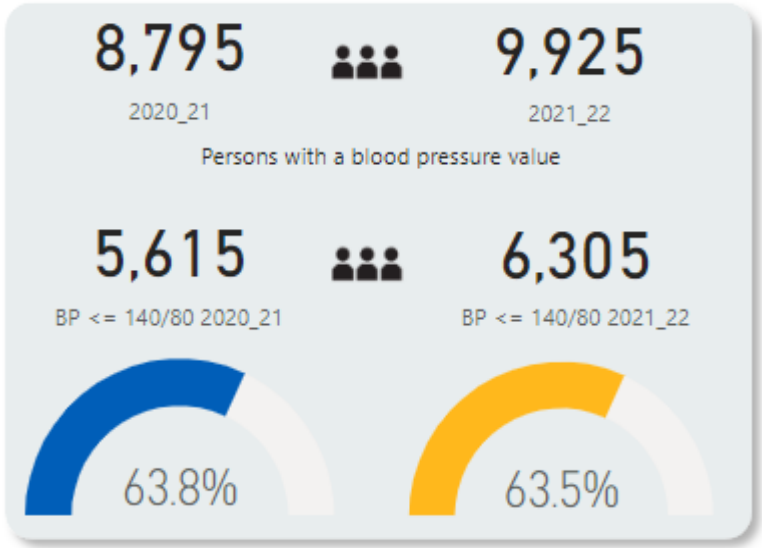
ABUHB



Meeting all 3 treatment targets – having HbA1c ≤58mmol/mol, blood pressure 140/80 and for people falling in the combined prevention CVD group: receiving statins.

	2020_21	2021_22
All 3 Treatment Target achieved	14.3%	13.9%
Statins Combined	65.3%	64.4%
Blood pressure <= 140/80	61.7%	61.7%
HbA1c <58mmol/mol	28.7%	27.1%

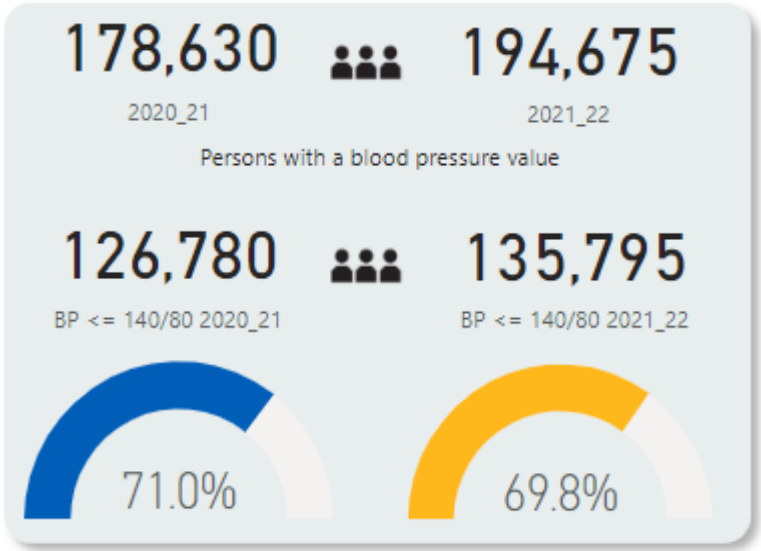
Wales



Meeting all 3 treatment targets – having HbA1c ≤58mmol/mol, blood pressure 140/80 and for people falling in the combined prevention CVD group: receiving statins.

	2020_21	2021_22
All 3 Treatment Target achieved	15.5%	15.9%
Statins Combined	65.0%	65.2%
Blood pressure <= 140/80	63.8%	63.5%
HbA1c <58mmol/mol	29.4%	31.2%

England



Meeting all 3 treatment targets – having HbA1c ≤58mmol/mol, blood pressure 140/80 and for people falling in the combined prevention CVD group: receiving statins.

	2020_21	2021_22
All 3 Treatment Target achieved	21.5%	22.4%
Statins Combined	69.5%	71.2%
Blood pressure <= 140/80	71.0%	69.8%
HbA1c <58mmol/mol	34.8%	36.3%

Treatment Targets across Wales and England have improved slightly from 2020/2021 to 2021/2022, however the Health Board is performing lower than the rest of the UK and has slightly declined in the latter year.

Key finding 1: Impact of pandemic

In Wales with the incidence (1) of type 1 diabetes rising year-on-year from 170 in 2018-19 to 245 in 2021-22.

There has been improvement in the completion of all 8 key care processes (2) in 2021-22 across all diabetes type following the reduction seen between 2019-20 and 2020-21 (the first pandemic year). However, in both people with type 1 diabetes and people with type 2 and other diabetes, care process completion remains below pre-pandemic levels. For example: people with type 1 diabetes in Wales, HbA1c care process completion rates were 71.4% in 2019-20, 61.3% in 2020-21 and 64.8% in 2021-22

- The care processes with the greatest drop from 2019-20 to 2020-21 in people with type 1 and type 2 and other diabetes in Wales were blood pressure, BMI and foot risk surveillance

- For all people across almost all the 5 years, urine albumin/creatinine ratio (3) was the lowest performer. In 2021-22 in Wales, 29.0% of people with type 1 diabetes received this care process and 47.8% of those with type 2 and other diabetes

Key finding 2: Inequalities in routine diabetes care delivery

Among people with type 1 diabetes and type 2 diabetes, people living in the most deprived quintile were the least likely to receive all 8 key care processes when compared to those living in less deprived areas in 2021-22.

- Younger people with type 1 diabetes and type 2 diabetes were the least likely to receive all 8 key care processes when compared to their older counterparts.

In Wales, 3.6% of people with type 1 diabetes aged 70-79 received no care processes, whereas the percentage was greater in those aged 17-24 at 25.4%. For people with type 2 and other diabetes, 3.5% of those aged 70-79 and 14.5% of those aged 17-24 received no care processes.

Key finding 3: Treatment target achievement trends

For all people with diabetes, percentages of those with blood pressure ≤ 140/80 showed no change from 2017-18 to 2019-20 but this reduced sharply during 2019-20 (the year of the pandemic) and failed to recover in 2021-22:

- For people in Wales with type 1 diabetes the percentage fell from 71.6% in 2017-18 to 63.5% in 2021-22 (see figure 9) and in people with type 2 and other diabetes the percentage fell from 68.4% in 2017-18 to 59.6% in 2021-22

There were no appreciable changes over 5 years in achievement of the statin prescription treatment target:

- In Wales, rates for people with type 1 diabetes were 67.3% in 2017-18 and 65.2% in 2021-22 (see figure 9), while the corresponding figures for people with type 2 and other diabetes the rates were 73.5% and 71.7%

Assurance and Risk

Assurance level	Description	Select
Significant	The project has mostly achieved the standards or criteria being audited against	Yes

Risk level	Description	Select
None	Standards met and findings demonstrate no risk to patient safety	Yes

Has this audit been placed on a Risk Register (N/A if above risk is None)	NO

Successes and Concerns

Report Successes:	
1	There has been an increase in the completion rate of all 8 care processes in 2021-22 compared to the preceding two years

Report Concerns:	
1	Completion of the 8 care processes needs to increase further and surpass pre pandemic levels and the impact of deprivation and widening age inequality needs to improve

Reported Recommendations:		Health Board Performance
1	Commissioners of care should continue to work with providers in restoring and then further improving pre-pandemic care process completion levels.	GP/primary care to continue to build on and improve the completion rate of all 8 care processes
2	Commissioners of care should work with providers to focus particularly on improving care process completion in young people and those living in the most deprived communities. The target should be levels already attained in people older than 70 years and in people living in the least disadvantaged areas.	GP/primary care needs to work with the All-Wales diabetes prevention programme to reduce the progression of prediabetes to diabetes where available – bring undertaken by GP practices based in defined NCN areas of Caerphilly and Blaenau Gwent.
3	Commissioners of care should work with providers of diabetes care to sustain progress in type 1 glucose control and restore pre-pandemic glucose control in people who have type 2 and other diabetes; and to first restore and then surpass pre-pandemic levels of blood pressure treatment target attainment in all people with diabetes.	All GP practices within ABUHB to fulfil the data collection on Unhealthy behaviours to help identify patients with obesity and so at increased risk of diabetes. GP practices to help support social prescribing to help reduce obesity via engagement with link works/community connectors etc.

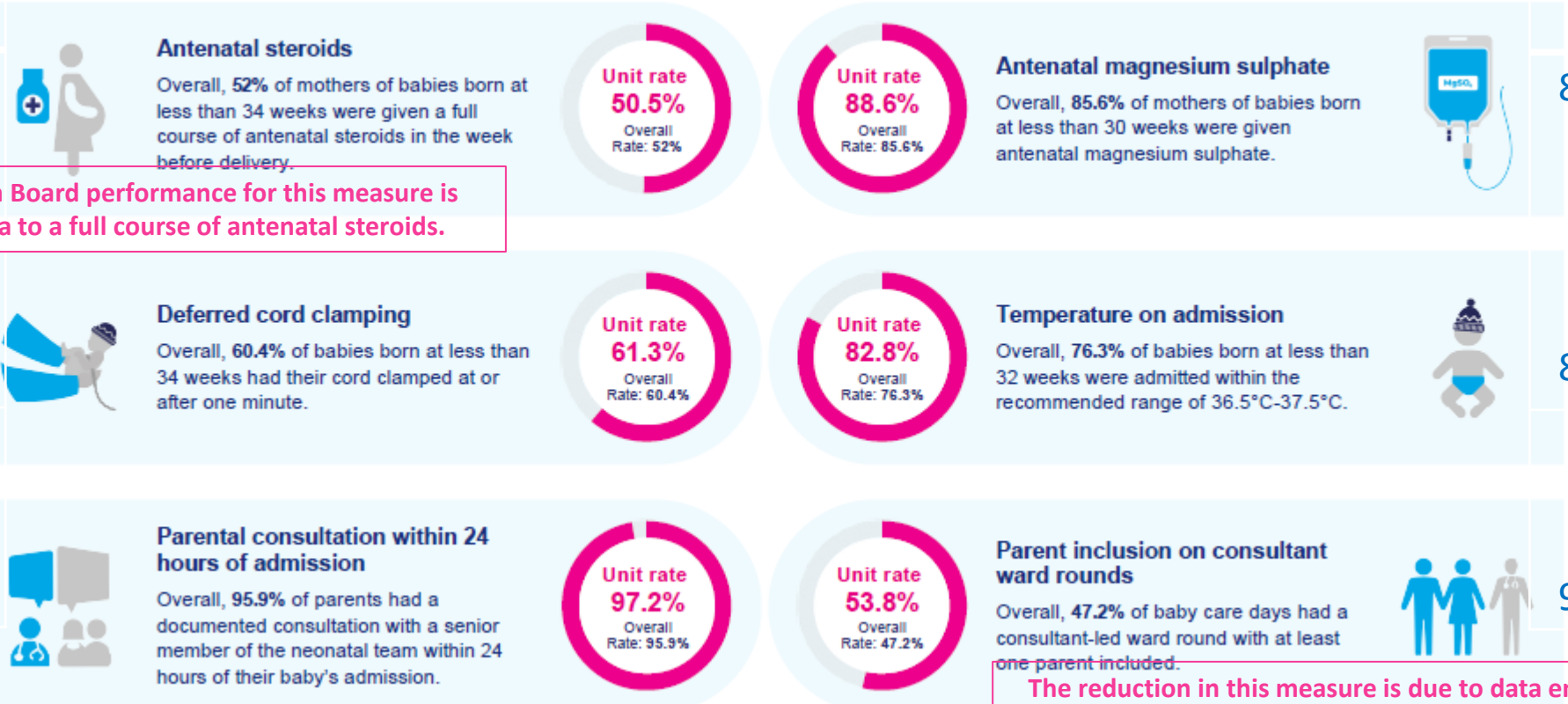
Appendix 10

Audit Title:	National Neonatal Audit Programme (NNAP) Summary report on 2022 data	Clinical Lead:	Dr Sunil Reddy
Rationale:	Established in 2006, the National Neonatal Audit Programme (NNAP) is commissioned by the Healthcare Quality Improvement Partnership (HQIP) and delivered by the Royal College of Paediatrics and Child Health (RCPCH). It assesses whether babies admitted to neonatal units receive consistent high-quality care in relation to the NNAP audit measures that are aligned to a set of professionally agreed guidelines and standards. The NNAP also identifies variation in the provision of neonatal care at local unit, regional network and national levels and supports stakeholders to use audit data to stimulate improvement in care delivery and outcomes.		
Objectives:	The audit reports key outcomes of neonatal care, measures of optimal perinatal care, maternal breastmilk feeding, parental partnership, neonatal nurse staffing levels, and other important care processes.		
Presented at Clinical Standards and Effectiveness Group – 30th November 2023			

The Grange University Hospital takes part in the National Neonatal Audit Programme (NNAP) which reports on aspects of care given to babies on neonatal units. This poster shows how selected 2022 results* for this hospital compare with overall (England, Scotland and Wales) performance.

How our unit did across selected NNAP measures:

Wales 2022	ABUHB 2021		ABUHB 2021	Wales 2022
51.7%	95%	**Antenatal steroids** Overall, **52%** of mothers of babies born at less than 34 weeks were given a full course of antenatal steroids in the week before delivery.	81.1%	85.3%
62.0%	30.2%	**Deferred cord clamping** Overall, **60.4%** of babies born at less than 34 weeks had their cord clamped at or after one minute.	80.0%	82.2%
97.2%	95.1%	**Parental consultation within 24 hours of admission** Overall, **95.9%** of parents had a documented consultation with a senior member of the neonatal team within 24 hours of their baby's admission.	96.1%	No data



The reduction in the Health Board performance for this measure is due to the change in criteria to a full course of antenatal steroids.

The reduction in this measure is due to data entry and work is ongoing with the nursing team to ensure data is accurately recorded.

The Health Board is performing better than the National Average in 5 of 6 measures, with Antenatal Steroids less than the National and Welsh average

The Grange University Hospital takes part in the National Neonatal Audit Programme (NNAP) which reports on aspects of care given to babies on neonatal units. This poster shows how selected 2022 results* for this hospital compare with overall (England, Scotland and Wales) performance.

The Health Board is performing better than the National Average in 3 of 6 measures, and in the four with Welsh data the Health Board is lower than in 4 measures

Wales 2022	ABUHB 2021		ABUHB 2021	Wales 2022
85.37%	59.7%	**Neonatal nurse staffing** Overall, **71.1%** of nursing shifts were staffed according to recommended levels. Unit rate 74.1%, Overall Rate: 71.1%	34.9%	No data
		Bronchopulmonary dysplasia (BPD) Overall, **39.7%** of babies born at less than 32 weeks† developed BPD or died. †discharged January 2020 to December 2022. Unit rate 40.6%, Overall Rate: 39.7%		
No data	70.3%	**Breastmilk feeding in the first two days** Overall, **49%** of babies born at less than 34 weeks received their mother's milk in the first 2 days of life. Unit rate 65%, Overall Rate: 49%	Not a measure	77.0%
		Breastmilk feeding at 14 days Overall, **79%** of babies born at less than 34 weeks received their mother's milk at 14 days of life. Unit rate 76.9%, Overall Rate: 79%		
57.5%	51.9%	**Breastmilk feeding at discharge** Overall, **62.9%** of babies born at less than 34 weeks received their mother's milk at discharge home. Unit rate 55.7%, Overall Rate: 62.9%	89.2%	58.2%
		Screening for retinopathy of prematurity (ROP) Overall, **69%** of eligible babies were screened on time for ROP. Unit rate 44.6%, Overall Rate: 69%		

ROP impacted by change to guidelines, early D/C, repatriation, DNA to clinic – Working closely with Ophthalmology team.

Outcomes of Neonatal Care as define in the report for 2022: *(other than BD, all measures lower than the National Average is a good result)*

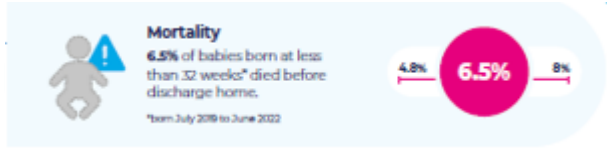
	NEC	No NEC
GUH	2.7%	97.3%
Wales	3.5%	96.5%
National	6.2%	93.8%

No local data relating to mortality in Wales

Grange University Hospital 3.9%

Grange University Hospital 40.6%





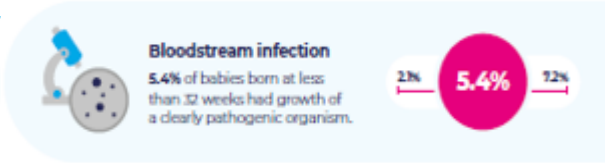




Table 16: Intraventricular haemorrhage (IVH) grades 3 or 4 or death, The Grange University Hospital

		Validated	Number Of Eligible Babies	Babies With Outcome	IVH34	IVH34 or Death (% of eligible babies)	Missing (%)
Place of Birth	The Grange University Hospital (NICU)	✔	71	70	5 (7.1%)	7 (10%)	1 (1.4%)
Unit level for comparison	NICU	✖	4 178	3 824	286 (593%)	593 (15.5%)	354 (8.5%)
Network	Wales		282	274	20 (7.3%)	32 (11.7%)	8 (2.8%)
National rate	All participating units		7 181	6 182	464 (7.5%)	906 (14.7%)	999 (13.9%)

Table 17: Cystic periventricular leukomalacia (cPVL) or death, The Grange University Hospital

		Validated	Number Of Eligible Babies	Babies With Outcome	cPVL	cPVL or Death (% of eligible babies)	Missing (%)
Place of Birth	The Grange University Hospital (NICU)	✔	71	69	1 (1.4%)	5 (7.2%)	2 (2.8%)
Unit level for comparison	NICU	✖	4 178	3 705	83 (2.2%)	415 (11.2%)	473 (11.3%)
Network	Wales		282	268	5 (1.9%)	22 (8.2%)	14 (5%)
National rate	All participating units		7 181	5 949	152 (2.6%)	598 (10.1%)	1 232 (17.2%)

Assurance Level and Risk Level

Assurance level	Description	Select	Risk level	Description	Select
Limited	The project did not achieve the standards or criteria being audited against	Yes	Minor	Single failure to meet internal standards/Minor implications for patient safety if unresolved	Yes
Has this audit been placed on a Risk Register (N/A if risk is 'None')					**No**

Key Success and Concerns

	Report Successes:
1	Deferred Cord Clamping was 30.2% for the Health Board in 2021 and increased to 61.3% in 2022
2	Parental Consultation within 24hours of admissions, was 95.1% and has increased to 97.2%.
3	Antenatal Magnesium Sulphate was given to 81.1% of mothers in 2021 and this has risen to 88.6% in 2022.
4	Temperature on Admission has increased form 80.0% in 2021 to 82.8% in 2022.
5	Neonatal Nurse Staffing was 59.7% in 2021 and has increased to 74.1% in 2022.
6	In the 2022 report, 76.9% were recorded as receiving mother milk in the first 2 days of life, however the 2021 report stated that this target was within 14 days (not 2) and was 70.3% - with a reduction in the days, the Health Board has increased performance.
7	Bronchopulmonary Dysplasia (BPD) for the Health Board was 34.9% in 2021 and increase slightly to 40.6% however the national rate in 39.7%.
8	Breast Milk at Discharge for 2021 was 51.9% and has increased to 55.7% in 2022 - nationally this is 62.9%

	Report Concerns:
1	Parent Inclusion on Consultant Ward rounds was doing well in 2021 at 96.1% however this has reduced to 53.8% in 2022. This is mainly due to data entry issue and as a group we working on nursing education to correctly enter data - combination of many issues : screening window, early D/C, ophthalmology managed, baby moved outside of unit. Trying to mitigate this and improve screening with ophthalmology team.
2	It was previously report within the Health Board that the Retinopathy of Prematurity was an excellent service within the Health Board, at 89.2% however for 2022 this rate has reduced to 44.6%

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Neonatal networks should review their rates of adverse outcomes (mortality, BPD, NEC, bloodstream infection and preterm brain injury), and develop locally prioritised action plans to respond to these results with their constituent neonatal units, and: • share these with Neonatal Network Boards, Local Maternity and Neonatal System (LMNS) Boards (and devolved nation equivalents), and with Trust/Health Board Governance Boards via ward-to-board Maternity or Neonatal Safety Champions. • work with their constituent neonatal units to ensure that all services have a plan in place to validate their data entry for outcomes such as necrotising enterocolitis, bloodstream infection, and preterm brain injury.	Ongoing work with nursing team to ensure all accurate and appropriate data is entered onto BadgerNet, including parental presence on ward rounds	Dr Reddy	31/03/2024	Ongoing
2	NHS England, Scottish and Welsh Governments should ensure that maternity data flows describe the administration of antenatal steroids, and other perinatal optimisation interventions, and that maternity and perinatal data are linked nationally in order to: • understand rates of timely exposure of preterm infants to perinatal optimisation interventions in the context of the number of women treated with steroids, magnesium sulphate and who require antenatal transfer, regardless of whether they go on to deliver significantly preterm, • improve reporting of neonatal outcomes of maternity care, in line with the recommendation made in 'Reading the signals' and to support national improvement initiatives.	Ongoing work with Ophthalmology to improve the ROP rates	Dr Reddy	31/03/2024	Ongoing

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
3	NHS England, Scottish and Welsh Governments should ensure that pre-term birth is optimally managed by a multidisciplinary team by: • ensuring that preterm birth lead teams (including an obstetrician, neonatologist, neonatal nurse and midwife) are commissioned at all neonatal services, • requiring that Integrated Care Systems (ICS), Health Boards in Scotland and Local Health Boards in Wales ensure that all neonatal services take a perinatal team approach to design and delivery of care that includes parents with diverse backgrounds and diverse experiences of neonatal care, • ensuring that perinatal teams conduct reviews of preterm birth cases to identify opportunities for improvement to maximise quality of care, and the delivery of the interventions identified by national improvement initiatives				
4	All Royal Colleges associated with preterm perinatal care (the Royal College of Paediatrics and Child Health, the Royal College of Obstetricians and Gynaecologists, the Royal College of Nursing and the Royal College of Midwives) should include a focus on the importance of early breastmilk feeding, and guidance on how to support parents to establish and sustain breastmilk feeding, in training relating to intrapartum care, fetal medicine care and perinatal care				
5	The UK Government, Welsh Government and Scottish Government should consider ways to ensure that the implementation of medium-to-long term NHS-wide workforce plans (such as the NHS Long Term Workforce Plan in England9) deliver the recruitment, training, development and retention of neonatal nurses to improve the proportion of shifts with sufficient staffing and therefore improve survival rates and the quality of care in neonatal units				

Appendix 11

Audit Title:	**National Early Inflammatory Arthritis Audit (NEIAA) Year 5 State of the Nation Report 2023** Data collection period: 1 April 2022 – 31 March 2023 Published October 2023	**Clinical Lead:**	**Dr Non Pugh, Consultant Rheumatologist**
Rationale:	The National Early Inflammatory Arthritis Audit (NEIAA) Measures quality of care delivered to patients in England and Wales aged 16 and over with suspected and newly diagnosed early inflammatory arthritis and is measured against NICE quality standards 33. It also assesses how inflammatory arthritis affects people's day-to-day function, mobility, sleep, wellbeing and ability to work		
Objectives:	The aim of the audit is to improve the care of patients with rheumatological immune mediated inflammatory disease and reduce current variation in care provision and outcome. By collecting this data, the audit aims to recommend standardised, effective, and patient-centred care pathways. Year 5 and first State of the Nation report presented data on five key metrics of care: • time to referral • time to assessment • time to treatment • response to treatment • patient-reported outcome measures		
Presented at Clinical Standards and Effectiveness Group 25th January 2024			

QS1 - People with suspected persistent synovitis affecting the small joints of the hands or feet, or more than one joint, are referred to a rheumatology service within three working days of presentation.

QS 2 - People with suspected persistent synovitis are assessed in a rheumatology service within three weeks of referral.

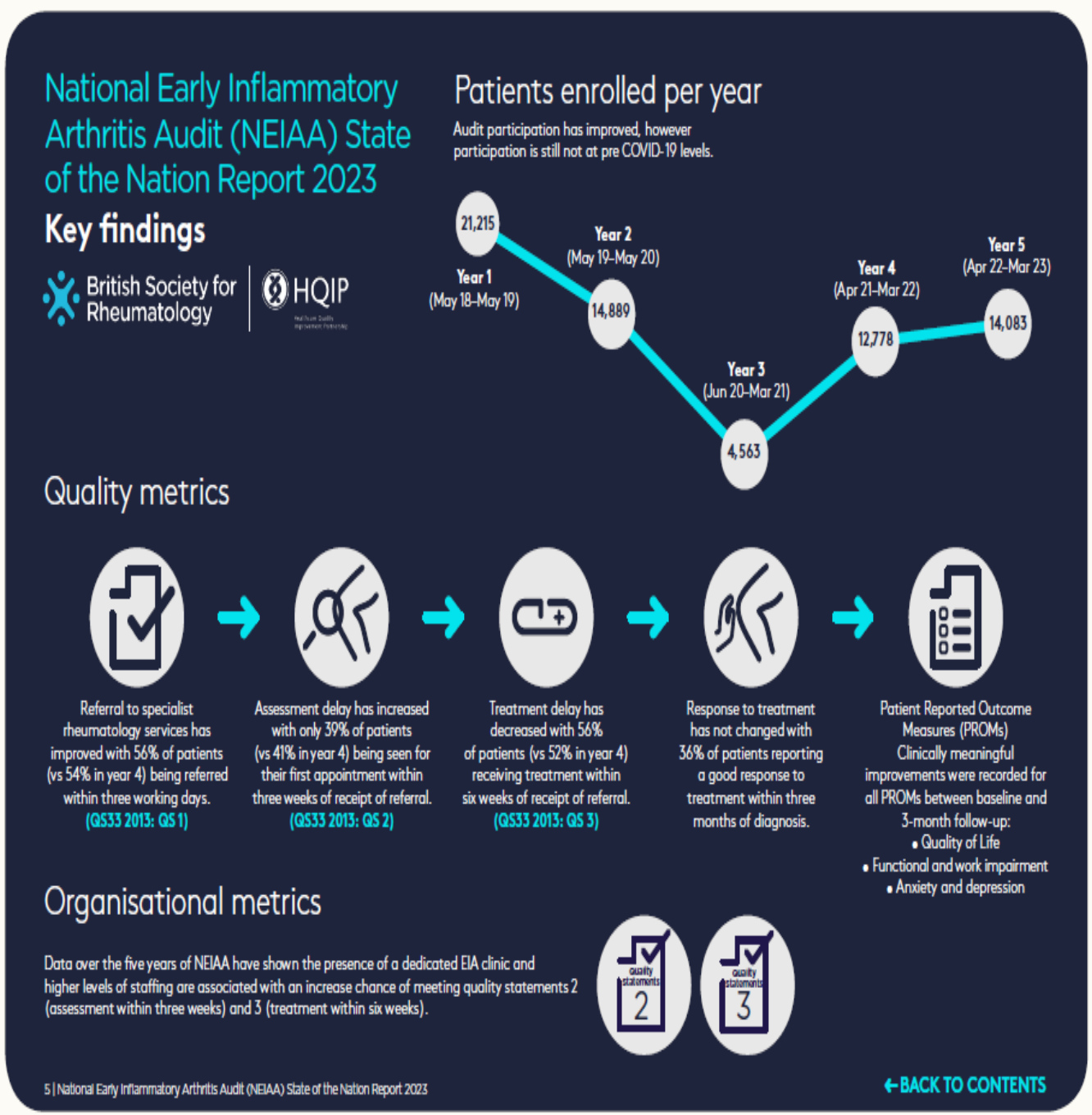
QS 3 - People with newly diagnosed RA are offered conventional disease-modifying anti-rheumatic drug monotherapy within three months of onset of persistent symptoms.

QS 4 - People with RA are offered educational and self-management activities within 1 month of diagnosis.

QS 5 - People who have active RA have their C-reactive protein (CRP) and disease activity measured monthly in specialist care until they are in remission or have low disease activity.

QS 6 - People with RA and disease flares or possible drug-related side effects receive advice within one working day of contacting the rheumatology service.

QS 7 - People with RA have a comprehensive annual review that is coordinated by the rheumatology service.



1	Ensure that public awareness is raised to encourage early presentation in primary care of people with suspected EIA and early referral into specialised rheumatology services. (QS33 2013: QS 1) Action by: National Patient Charities
2	EIA pathways should be mandated in secondary care to provide timely assessment, diagnosis and access to treatment for patients with EIA.(QS33 2013: QS 2 & 3) Action by: Integrated Care Boards (ICBs, England) and NHS Health Boards (Wales
3	NEIAA data alongside the strategies described in the elective recovery programme, GIRFT and the outpatient recovery and transformation programme must be used to inform and expediate post COVID-19 pandemic recovery strategies for secondary care rheumatology services. Action by: Care Quality Commission (CQC, England) and Healthcare Inspectorate Wales (HIW)
4	Collection of outpatient secondary care diagnostic information should be mandated as a priority to inform service design and delivery. (GIRFT recommendations 7 and 8) Action by: NHS England and NHS Wales
5	The rheumatology Multi-Disciplinary Team (MDT) provision should be expanded to meet the rising demand and expectations in line with recommendations in the BSR rheumatology workforce report.(QS33 2013: QS 2 and 3) Action by: Secretary of State for Health and Social Care

ABUHB Data April 2022 – March 2023

Number of patients : 513- highest no. in Wales and 2nd nationally

QS1 Referral to specialist rheumatology service within three working days.

ABUHB 83.20% (69% year 4)

National 56% (54% year 4)
All Wales 60%

QS2 Patients being seen for their first appointment within three weeks of receipt of referral.

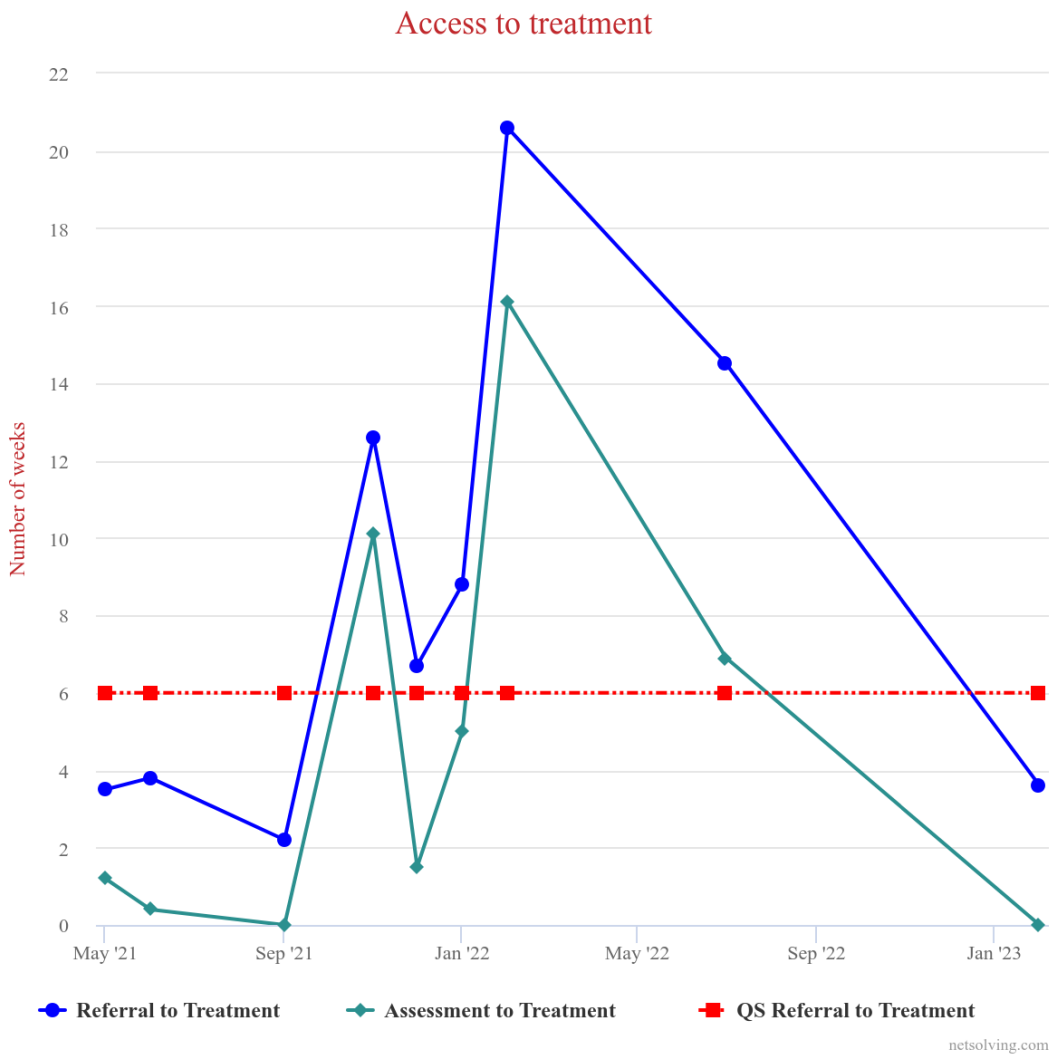
ABUHB 14 % (22% year 4)- defined as OUTLIER alarm status –
Outlier threshold for ABUHB: 34%

National 39% (41 % year 4)
All Wales 25 %

QS3 Patients receiving treatment within six weeks of receipt of referral.

ABUHB 19% (83% year 4)

National 56% of patients (52% year 4)
All Wales 46 %



ABUHB Data April 2022 – March 2023

QS4. patients with confirmed EIA offered access to education and information on self-management

ABUHB 97 % (87)

QS5- patients with confirmed EIA had treatment target set and agreed.

ABUHB 97 % (77)

QS6- patients provided with access to rheumatology specialist advice (e.g., a telephone advice line).

ABUHB 100 % (94)

Quality standard	ABUHB 2020	ABUHB 2021	ABUHB 2022	ABUHB 2023	National 2023	Wales 2022
QS1 %	72	72	69	83	56	60
QS2 %	29	74	22	14	39	25
QS3 %	73	91	83	19	56	46
QS4 %	92	92	87	97	56	95
QS5 %	75	75	77	97	90	88
QS6 %	92	92	94	100	95	96

NEIAA results - from April 2023

Improvements in QS2 and QS3 but audit criteria has changed as only patients with definite EIA are now included

Aneurin Bevan UHB Rheumatology Service [from: 01/04/2023 - to: 31/12/2023]

Quality Statement 1	
Total number of patients recruited	408
Number of patients referred via EIA pathway	404
Number of patients referred within 3 working days	382
% patients referred within 3 working days	93.6%

Quality Statement 2	
Total number of patients recruited	408
Number of patients referred via EIA pathway	404
Number of patients seen within three weeks	130
% patients seen within three weeks	31.9%

Quality Statement 3	
Total number of patients commencing EIA follow up	27
Number of patients started DMARD within 6 weeks	21
% DMARD started within 6 weeks of referral	77.8%

Aneurin Bevan UHB Rheumatology Service [from: 31/10/2023 - to: 31/12/2023]

Quality Statement 1	
Total number of patients recruited	3
Number of patients referred via EIA pathway	3
Number of patients referred within 3 working days	1
% patients referred within 3 working days	33.3%

Quality Statement 2	
Total number of patients recruited	3
Number of patients referred via EIA pathway	3
Number of patients seen within three weeks	2
% patients seen within three weeks	66.7%

Quality Statement 3	
Total number of patients commencing EIA follow up	3
Number of patients started DMARD within 6 weeks	0
% DMARD started within 6 weeks of referral	0.0%

Reasons for outlier status for QS2

- Outlier status was expected from regular review of the audit dashboard/reports and regular discussion at directorate and DPSQ meetings
- **Similar issues with clinic booking as 2021-22 as no improvements and main reason for being an outlier**
- Urgent clinic appointments available but ? EIA patients not booked into *urgent next available clinic* and booked same time or later than *urgent* patients
- Routine waiting list reduced as new consultant initially only seeing new patients and some routine patients booked within 8 weeks but ? EIA patients booked after 4 weeks
- Also booking staff shortages and new staff
- Clinics at multiple sites and some patients seen later than 3 weeks as they declined an earlier appointment as requested to be seen at a different hospital but this is not captured in the audit

Discussion with NEIAA audit lead

- Having met with the team and discussed the issues with them we have identified some areas of good practice that we wish to highlight and areas where we feel the team need Trust support.
- In line with recommendations from the Getting It Right First Time (GIRFT) initiative the rheumatology team are practicing Consultant level triage including 'rejecting' non-inflammatory referrals and triaging patients to protected EIA slots. Unfortunately, post-triage there are significant delays with booking the appointment.
- This is partly due to in-house delays with the booking process but is also hampered by the wide geographical catchment meaning patients often turn down the first available appointment, preferring to wait for an appointment at a site nearer to home.
- The team would benefit from dedicated administrative & booking support and Audit Department engagement to help manage the increasing data burden with the widening scope (data entry is mandated for new diagnosis of Connective Tissue Diseases and vasculitis from 1st September 2023).

Assurance and Risk

Assurance level	Description	Select
Limited	The project did not achieve the standards or criteria being audited against	Yes

Risk level	Description	Select
Minor	Single failure to meet internal standards/Minor implications for patient safety if unresolved	Yes

Has this audit been placed on a Risk Register? (N/A if above risk is 'none')	**Yes/No**
If not on a risk register, why not:	

Key Success and Concerns

Report Successes:	
1	QS1 improved
2	QS4, QS5 and QS6 improved

Report Concerns:	
1	QS2 results lower than previous year as no improvements in clinic booking
2	QS3 results lower as patients not booked within 3 weeks and many > 6 weeks

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Ensure that public awareness is raised to encourage early presentation in primary care of people with suspected EIA and early referral into specialised rheumatology services. (QS33 2013: QS 1) *Action by: National Patient Charities*	Action is for outside of the Secondary Care			
2	EIA pathways should be mandated in secondary care to provide timely assessment, diagnosis and access to treatment for patients with EIA. (QS33 2013: QS 2 & 3) *Action by: Integrated Care Boards (ICBs, England) and NHS Health Boards (Wales)*	Triage clinic and EIA pathway in place For improved clinic booking within 3 weeks via changes to clinic slots and advice to booking team- see local recommendations for further details	Directorate and booking team	Nov 2023 and for 2 monthly review	Improvement in clinic booking and QS2 and QS3
3	NEIAA data alongside the strategies described in the elective recovery programme, GIRFT and the outpatient recovery and transformation programme must be used to inform and expediate post COVID-19 pandemic recovery strategies for secondary care rheumatology services. Action by: Care Quality Commission (CQC, England) and Healthcare Inspectorate Wales (HIW)	Action is for outside of the Secondary Care			
4	Collection of outpatient secondary care diagnostic information should be mandated as a priority to inform service design and delivery. (GIRFT recommendations 7 and 8) Action by: NHS England and NHS Wales				
5	The rheumatology Multi-Disciplinary Team (MDT) provision should be expanded to meet the rising demand and expectations in line with recommendations in the BSR rheumatology workforce report. (QS33 2013: QS 2 and 3) Action by: Secretary of State for Health and Social Care				

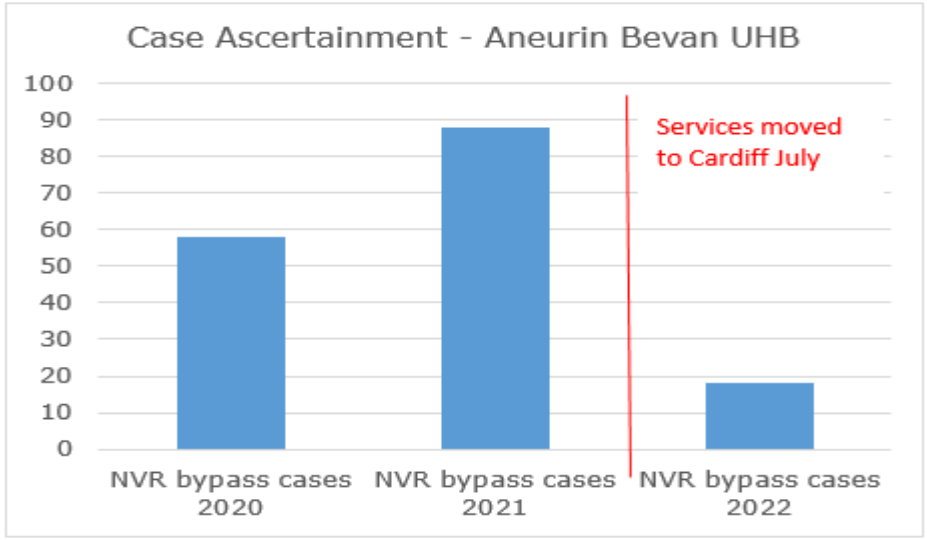
Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Re: outlier status for QS2- Need improved clinic booking into urgent EIA slots within 3 weeks and this should also lead to an improvement in QS3	**Booking changes made by covering DM in October 2023-** • creating specific EIA slots • Ensuring we have a surplus of these slots each week • Asking bookings to book within 3 weeks to ensure compliance • Cancel lower priority if needed. • Consultant determining and communicating referrals as 'EIA within 3 weeks' rather than 'next available clinic' • Improving communication with patients to highlight the importance of attending urgent appointments • Enhanced monitoring and oversight of compliance with the 3-week target	Directorate and booking teams	Nov 2023 and for regular review at directorate meetings	Changes already actioned and EIA slots in place with improvement in clinic booking, QS2 and QS3

Appendix 12

Audit Title:	**National Vascular Registry State of the Nation Report 2023** **Results for patients who had vascular procedures during 2022 in NHS hospitals in England, Wales, Scotland and Northern Ireland**	**Clinical Lead:**	**Mr David McLain – Vascular Surgeon**
Rationale:	The National Vascular Registry (NVR) was established in 2013 to measure the quality and outcomes of care for adult patients who undergo major vascular procedures in NHS hospitals, and to support vascular services to improve the quality of care for these patients.		
Objectives:	The aim of the National Vascular Registry (NVR) is to measure the quality and outcomes of care for patients who undergo major vascular surgery in NHS hospitals, and so support vascular units in the UK to improve the quality of the care received by patients. The NVR aims to improve the care of five main vascular procedures: • Repair of abdominal aortic aneurysm (AAA) • Carotid endarterectomy • Lower limb angioplasty • Lower limb bypass • Lower limb amputation		
Presented to Clinical Standards and Effectiveness Group – 25th January 2024			

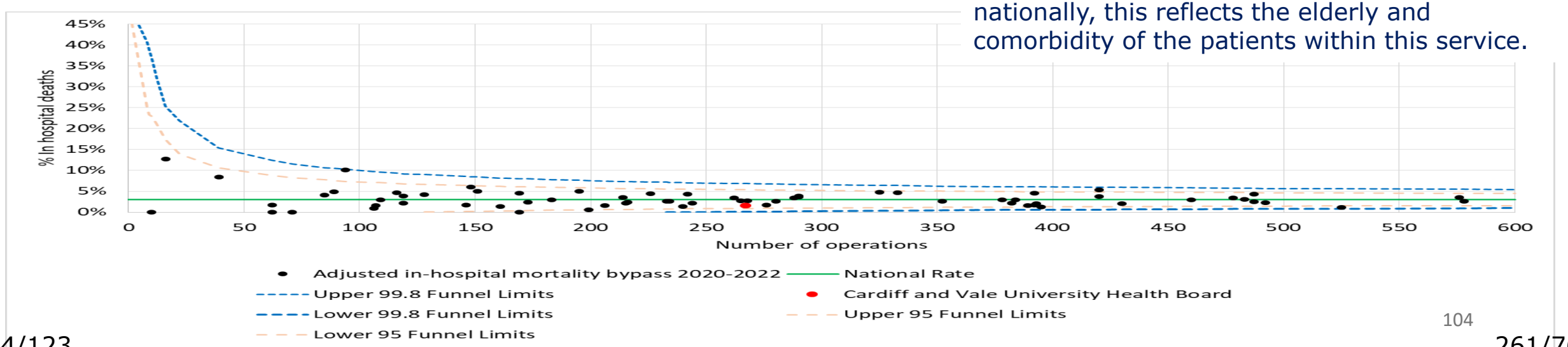
The numbers of NVR bypass cases increased from 2020 to 2021 within the Health Board with a large reduction in 2022, this was due to the service moved to Cardiff in July 2022

The Health Board **NVR BYPASS** has 0% 30-day readmission rate for 2022 with the Wales rate 12.7% and 3.4% Adjusted in-hospital mortality rate compared to Wales 3.0%.

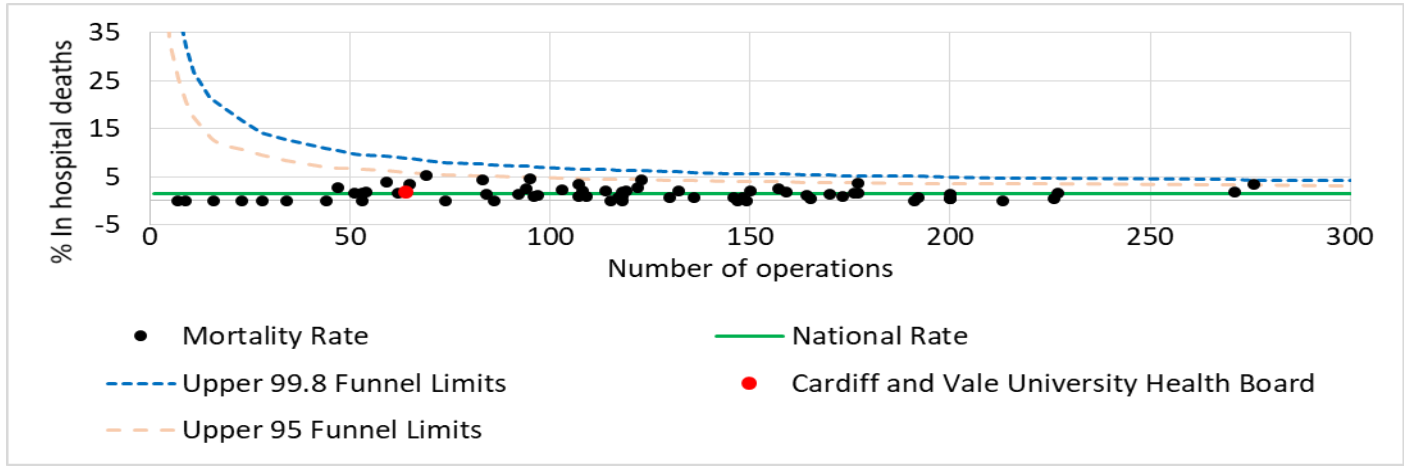


Trust Name	NVR cases 2022	NVR cases 2020-2022	Median (IQR) length of stay (days) 2022	% Adjusted in-hospital mortality 2020-2022	Readmission within 30 days 2022
C&VUHB	130	267	9 (6-21)	1.6%	12%
NATIONAL	6,432	17,967	8 (4 - 16)	3.0%	11.6%

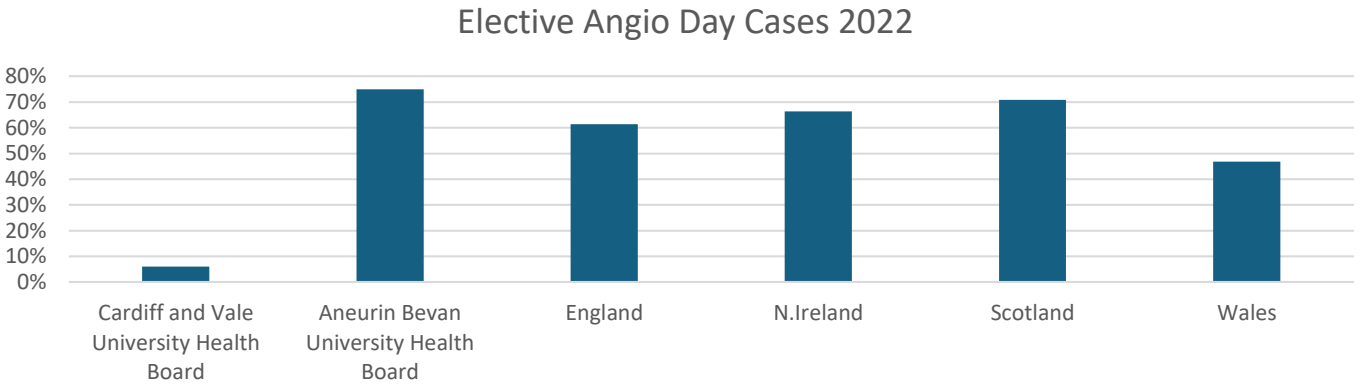
Bypass surgery median LoS for SEWVN is 9 days compared to nationally 8 days, with 1.6% adjusted in-hospital mortality compared to the national rate of 3.0% and re-admission rates within 30 days are 12% for SEWVN and 11.6% nationally, this reflects the elderly and comorbidity of the patients within this service.



The SEWVN mortality rate for AAA is on par with the rest of the UK. The aspirational target is that patients receiving surgery within 8 weeks (56 days) however the Health Board was only achieving 12% compared to 32% nationally.



Angioplasty performed in the SEWVN was 6% due to a lack of day case beds compared to the national rate of 61%, when this service was carried out in The Grange University Hospital, the rate was 75%. The Health Board patients were getting a better-quality service before the commencement of SEWVN.

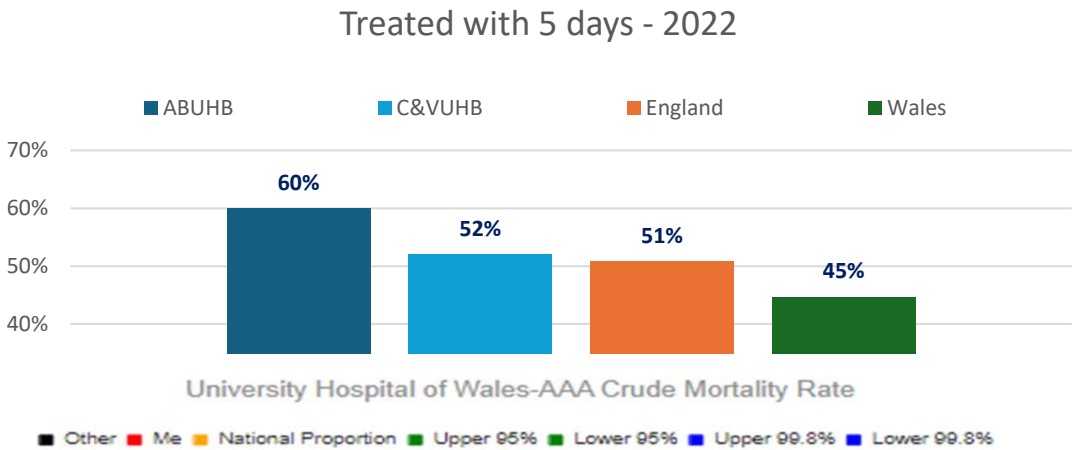


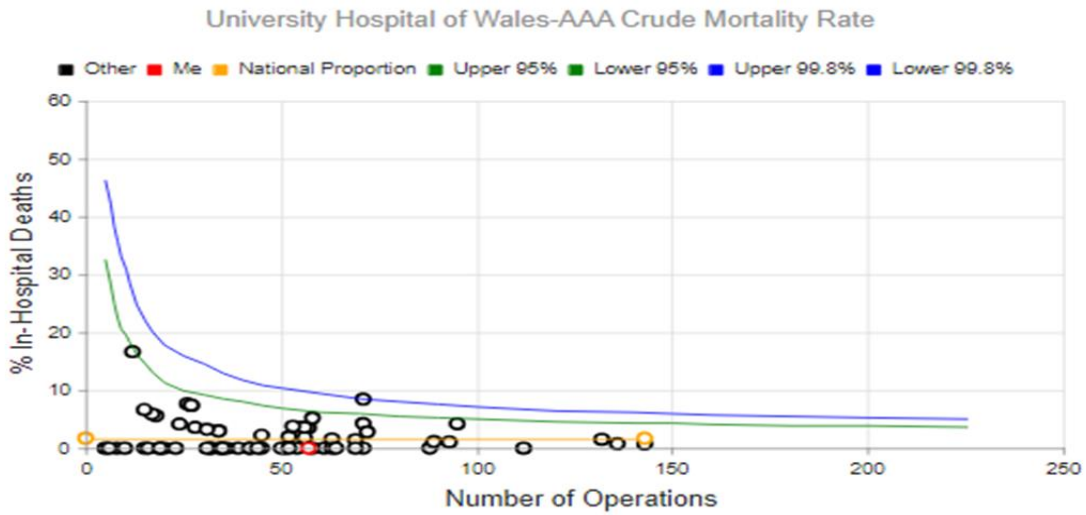
It is important where possible to perform Below Knee Amputation (BKA) rather than Above Knee Amputation (AKA) this forms the AKA:BKA ratio, which ideally needs to be under one, and the SEWVN is 0.58 compared to nationally 0.89.

The SEWVN shows 89% of the time there is a consultant in theatre which is performing better than the national rate of 74%.

Trust Name	NVR Cases in 2022	Median - vascular assessment to amputation (days) for non-elective admissions (2022)	Median (IQR) length of stay (days) (2022)	AKA: BKA (2022)	% Consultant Present in Theatre (2022)	% Prophylactic Antibiotics (2022)	Adjusted 30 day in-hospital mortality (2020-2022)
C&VUHB	112	10 (3 - 21)	21 (15 - 37)	0.58	89%	100%	8.4%
NATIONAL	3,505	7 (3 - 20)	22 (14 - 38)	0.89	74%	90%	6.5%

Patients admitted non-electively (emergency) with chronic limb-threatening ischaemia (CLTI) should have a revascularisation procedure within five days and those seen at outpatients should be seen within 14 days. During 2022 the Health Board rate was 60% of patients treated within 5 days (emergency) compared to the UK average of 51% and Wales average of 45%.





Organisation Name	All Cases	Cases with Outcome Data	In-Hospital Deaths	Mortality Rate
University Hospital of Wales	57	57	0	0

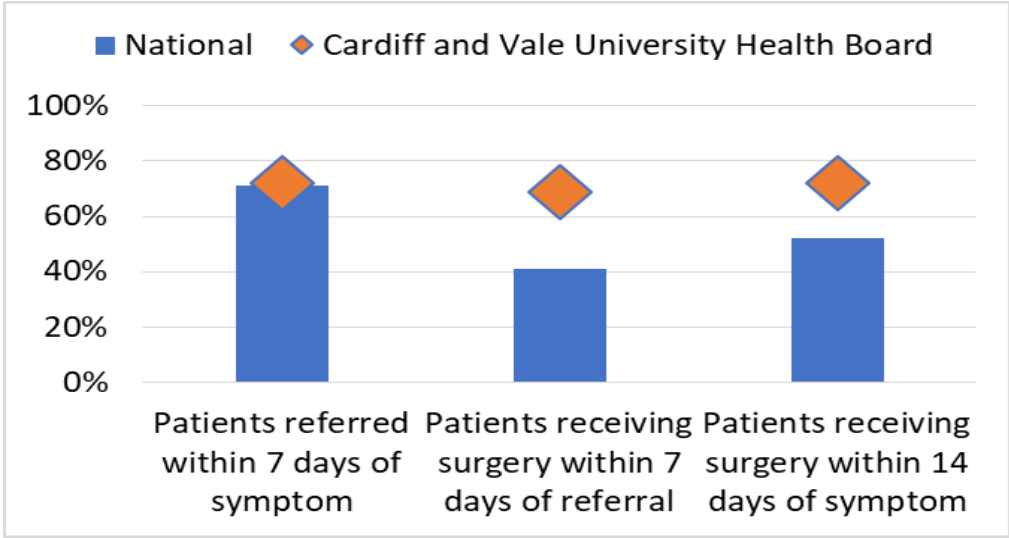
The Health Board also reported lower Length of Stay (LoS) rates due to excellent step-down rehabilitation services.



Data from the first 12 months of the SEWVN July 22 – July 23 which indicate that elective aneurysm mortality is very good at 0% and more procedures are Endovascular Aneurysm Repairs (EVAR) which is minimally invasive compared to open procedures, with 38% mortality which is respectable for the type of patients and from symptom to surgery is 13 days.

Carotid Endarterectomy (CEA) target is patients should have surgery within 14 days of their index event and that split, allows seven days for the referral to vascular surgery and then seven days from the point of referral to surgery, making the network above the national average.

The Royal College of Surgeons are providing quarterly reports, so there is not waiting to the end of the year report to react to performance.



Performance and Constraints reports relating to the first 12 months of the SEWVN July 22 – July 23 which indicate that elective aneurysm mortality is very good at 0% and more procedures are Endovascular Aneurysm Repairs (EVAR) which is minimally invasive compared to open procedures, with 38% mortality which is respectable for the type of patients and from symptom to surgery is 13 days.

Trust Name	Trust code 7A4	NVR Cases	No. of EVAR	Median (IQR) length of stay for open repairs (days)	Median (IQR) length of stay for EVAR (days)	Median Time (IQR) From Assessment to Procedure (days)	% of Patients Receiving Surgery Within 8 Weeks of Assessment	Risk-adjusted in-hospital mortality (2020-2022)
C&VUHB		34	9	9 (8 - 10)	2 (2 - 2)	128 (78 - 164)	12%	1.9%
NATIONAL		2,833	1,689	7 (6 - 10)	2 (1 - 3)	87 (48 - 146)	32%	1.4%

Assurance and Risk

Assurance level	Description	Select
Significant	The project has mostly achieved the standards or criteria being audited against	Yes

Risk level	Description	Select
Minor	Single failure to meet internal standards / Minor implications for patient safety if unresolved	Yes

Has this audit been placed on a Risk Register (N/A if above risk is None)	No
If not on a risk register, why not: This service is outside of the Health Boards remit and is managed by Cardiff & Vales UHB.	

Successes and Concerns

Successes	
1	Clinical outcomes satisfactory.
2	Pre-centralisation – good performance for carotids and CLI times

Concerns	
1	Process measures poor since centralisation
2	Time to revascularisation
3	Time to amputation
4	Time to AAA repair

	Report Recommendations:	S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Ensure that patients with chronic limb threatening Ischaemia (CLTI) receive care as recommended in the VSGBI Quality Improvement Frameworks (QIF) for peripheral arterial disease and are treated with sufficient urgency: • aim for 60% of non-elective admitted patients to have a revascularisation procedure within 5 days, *in keeping with the 2022-23 CQUIN (rising to 65% in the 2023-24 CQUIN). Please note that the CQUIN only applies in England.*	Streamline imaging pathways and fast-track urgent inpatient imaging			
2	Ensure that patients who have major lower limb amputation receive care as recommended in the VSGBI Quality Improvement Framework (QIF) and avoid long delays to surgery after vascular assessment. Below knee amputation should be performed whenever appropriate.	Provide adequate and timely rehab and step-down beds Provide adequate theatre time			
3	Ensure that pathways for patients with aortic aneurysms avoid undue delays, and make efforts to meet the recommended 8-week standard for elective repair of abdominal aortic aneurysms (AAA)				

	Report Recommendations:	S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
4	Commissioning of vascular units to perform FEVAR / BEVAR aortic procedures should be conditional on the unit submitting data on all such cases to the NVR so that activities and outcomes can be monitored. Vascular units should enter data on all TEVAR procedures on the NVR to support regional delivery of the Acute Aortic Dissection Toolkit.	Appoint a data clerk to capture and enter NVR data on all index cases. Developing a complex EVAR service.			
5	Ensure timely referral and expedited surgery for patients with symptomatic carotid disease with measures to reduce waiting times to carotid endarterectomy (CEA)	Largely being achieved.			

	Clinical Leads Local Recommendations: (if applicable)	S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	See SEWVN Governance reports for review and recommendations. Constraints/Performance				
2	Challenges in SW Wales Vascular service, particularly IR provision.				

Appendix 13

Audit Title:	**National Prostate Cancer Audit (NPCA) State of the Nation report** Data collection period: 1 January 2019 – 31 January 2023 Published January 2024	**Clinical Lead:** **Mr Adam Cox –** **Consultant Urological Surgeon**
Rationale:	Prostate cancer is the most common solid cancer in men with over 46,000 new cases diagnosed each year in the UK and its incidence is increasing. There are concerns about over-diagnosis and over-treatment in men with low-risk disease, while men with locally advanced or high-risk disease may not be getting the radical treatments that they need.	
Objectives:	Its aim is to evaluate the patterns of care and outcomes for patients with prostate cancer in England and Wales, and to support services to improve the quality of care.	

Results

Presented at Clinical Standards and Effectiveness Group 21st March 2024

Management	Specialist MDI	National	Health Board Database
No. of men diagnosed with low-risk localised disease	40	3680	ABUHB internal database records higher case ascertainment.
Percentage of men with low-risk localised disease receiving radical treatment	5 %	9 %	
No. of men diagnosed with locally advanced disease	100	11503	
Percentage of men diagnosed with locally advanced disease receiving radical treatment	68 %	69 %	Comparable to N/A

Data Quality	Diagnosing Trust	Clinical Lead update
No. of Cancer Registry records	344	Query the quality of the data presented for ABUHB.
Performance Status recorded	100 %	
PSA completed	72 %	*The Health Board figure would be in the high 90% as this is a standard diagnostic test.*
Gleason Score completed	72 %	*A grading score that is routine for all patients, expectations of high 90%.*
TNM completed	79 %	
Risk group assigned	86 %	*This result can be impacted on if risk group assigned before staging scans are performed*

Outcome	Treatment Centre	Health Board Database
No. of men who received radical prostatectomy (Apr 2021 – Mar 2022)	37	57
Adjusted percentage of men who had an emergency readmission within 90 days of radical prostatectomy	10 %	Increase in numbers will impact this % - Max 1 readmission in 12 months. Readmission can include post op contacts, telephone advice, clinic.
No. of men who received radical prostatectomy (Sep 2019 – Aug 2020)	42	HB Database records 80 cases Sep 19-Aug 20. HB have cases 67 in 12 months.
Adjusted percentage of men experiencing at least one GU complication	10 %	England recording 10% and Wales 5%.

Risk level	Description
None	Standards met and findings demonstrate no risk to patient safety

Assurance level	Description
Full	The project has fully achieved the standards or criteria being audited against

Report Successes:	
1	First UK centre to do same day discharge for robotic prostatectomy
2	Recently appt a 3rd Consultant Oncologist to the MDT
3	Recently appt Consultant Radiologist to the MDT
4	Business case approved for intuitive da-vinci surgical robot in Aneurin Bevan

Report Concerns:	
1	Data on re-admission is inaccurate
2	Data on number of surgical cases is inaccurate

	Report Recommendations:	S.M.A.R.T Actions: Listed in AMaT as Responsible: Due Date: Progress:
1	Aim to achieve high completeness of key data items at the point of collection by NHS organisations in England, particularly tumour, node and metastasis (TNM) staging variables. Action by: NHS England and Health Boards in Wales; Prostate cancer teams (local and Specialist MDTs) within NHS Trusts	Done in real time with Cancer Services Coordinator with any missing data requested by Royal College. Review plan for data acquisition with Cancer Lead.
2	Continue to advocate active surveillance for men with low-risk prostate cancer. Action by: NHS England and Health Boards in Wales; Professional bodies (Royal College of Radiologists, British Association of Urological Surgeons, Prostate Cancer UK)	Already doing this – better than NA on accurate data - 8% England 9% Wales
3	Investigate why men with high-risk/locally advanced disease are not considered for radical treatment and aim for 75% offered radical treatment. Action by: NHS England and Health Boards in Wales; Cancer Alliances (CA).	AB better than the 68% recorded as data inaccurate. 69% England and 69% Wales
4	Review variation between providers in rate of GU/GI complications and 90 day readmission rates. Action by: NHS England and Health Boards in Wales; Professional bodies (Royal College of Radiologists, British Association of Urological Surgeons); Cancer Alliances	Genitourinary complications returns for England was 7%, Wales 8% & ABUHB 10% however inappropriate returns (clinic/telephone advice) will impact this result for the Health Board. No Gastrointestinal data for ABUHB, however Wales is performing better than England at 5% compared to 10%. In England 13% of men were re-admitted within 3 months following surgery, that was 9% for Wales, ABUHB recorded as 10% however CL states that possibly one legitimate return was experienced in ABUHB.
5	Cancer Alliances should review processes of care to ensure equitable implementation of new technologies and pathways of care as evidence evolves. Action by: NHS England and Health Boards in Wales; Professional bodies (Royal College of Radiologists, British Association of Urological Surgeons); Cancer Alliances	Urology Cancer Network for Wales continuously evaluates service provision across the Health Boards, introducing new technologies, pathways of care, medication.

	Clinical Leads Local Recommendations: (if applicable)	S.M.A.R.T Actions:
1	Employ 1-2 CNS to support recent resignation and the PSA patient self-management software	Write business case

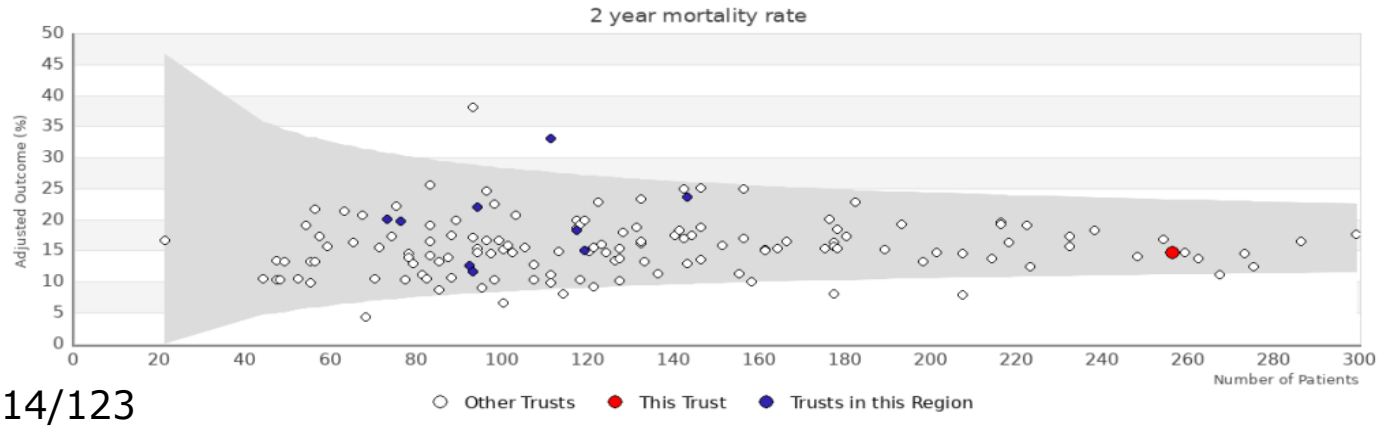
Appendix 14

Audit Title:	NBOCA – National Bowel Cancer Audit – State of the Nation Report An audit of the care received by people with bowel cancer in England and Wales focusing on people diagnosed between 1 April 2021 and 31 March 2022. Published 8 February 2024.	Clinical Lead: Mr Keshav Swarnkar
Rationale:	The National Bowel Cancer Audit (NBOCA) measures the quality and outcomes of care for patients diagnosed with bowel cancer in England and Wales. It supports hospitals in England and Wales to improve the quality of the care received by patients.	
Objectives:	NBOCA collects data on items which have been identified as good measures of clinical care. It compares variation between English NHS trusts or hospitals, and Welsh MDTs, as well as changes in care over time.	

Presented at Clinical Standards and Effectiveness Group – 21st March 2024

Patients having major resection:	Trust	Network	National
Circumferential resection margin: Negative (%)	85	86	83
Rectal volume	75	N/A	4377

Patients in APER/Hartmanns estimate:	Trust	Network	National
Number of patients in APER/Hartmanns estimate	171	1145	19644
APER/Hartmanns (%)	42	45	37



Trust	Number	Adjusted	Observed
Aneurin Bevan University Health Board MDT	256	14.8%	17.1%
Other trusts within the region: Wales			
Cardiff MDT	93	11.7%	11.4%
West Wales General & Prince Phillip MDT	143	23.7%	29.1%
Prince Charles Hospital MDT	76	19.7%	22.1%
Princess of Wales MDT	73	20%	28.7%
Royal Glamorgan Hospital MDT	92	12.7%	17.9%
Swansea MDT	117	18.3%	22.8%
Ysbyty Glan Clwydd MDT	94	22.1%	22.9%
Ysbyty Gwynedd MDT	119	15%	21.8%
Ysbyty Maelor MDT	111	33%	30.2%

Aneurin Bevan University Health Board - Data Quality:

All Patients:	Trust	Network	National
Number of patients in Audit	461	2335	35779
Case ascertainment (%)	Good	Good	Good
Data completeness of:			
– Pre-treatment TNM (%)	91	96	86
– Performance status (%)	100	98	89

Patients having major resection:	Trust	Network	National
Number of patients in Audit	291	1436	19631
ASA grade 1 (%)	9	6	9
ASA grade 2 (%)	45	49	53
ASA grade 3 (%)	39	37	31
ASA grade 4+ (%)	4	7	2
ASA grade not recorded (%)	4	1	4
Data completeness of:			
7 Audit items for risk-adjustment (%)	91	95	87

All Patients:	Trust	Network	National
Number of patients in Audit	461	2335	35779
Seen by Clinical Nurse Specialist (%)	91	88	88

All patients deemed potentially curative	Trust	Network	National
Number of potentially curative patients	N/A	N/A	N/A
Undergoing major resection (%)	N/A	N/A	N/A

Patients having major resection:	Trust	Network	National
Number of patients in Audit	291	1436	19614
Distant metastases (%)	8	8	5
Urgent or emergency surgery (%)	19	18	15
At least 12 lymph nodes excised (%)	87	89	84
Laparoscopic surgery attempted (%)	57	65	72
Risk-adjusted length of stay > 5 days (%)	62	60	55

Patients having major resection for stage III colon cancer:	Trust	Network	National
Number of patients in audit	135	N/A	10747
Adjuvant chemotherapy (%)	42	N/A	62

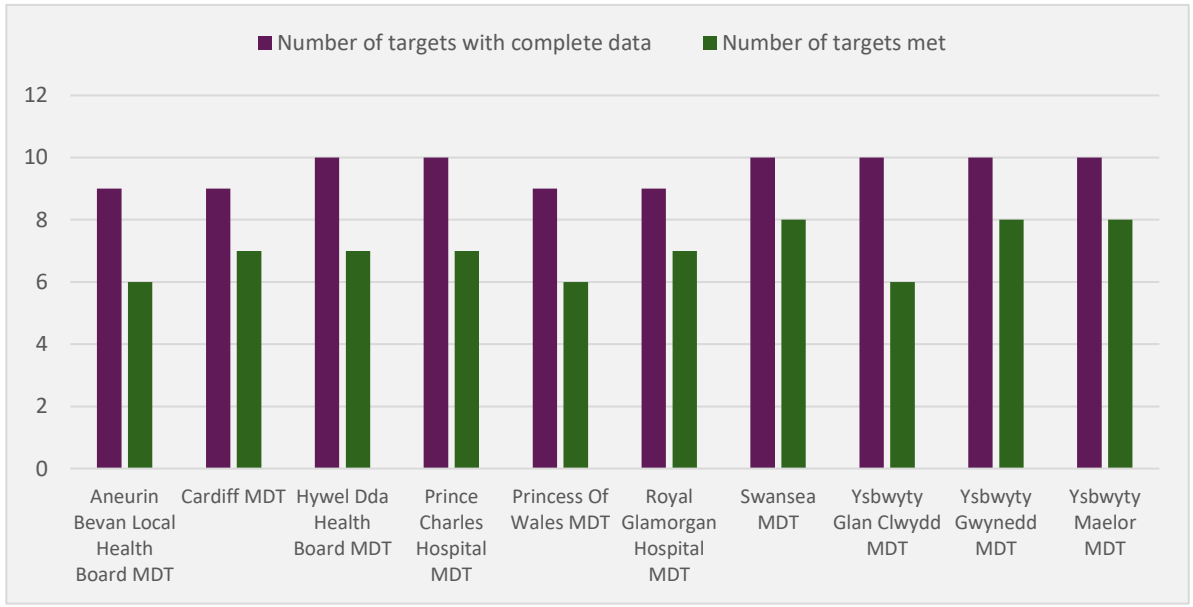
Patients receiving chemotherapy after major resection for stage III colon cancer:	Trust	Network	National
Number of patients in audit	N/A	N/A	6608
Severe acute toxicity after adjuvant chemotherapy (%)	N/A	N/A	22

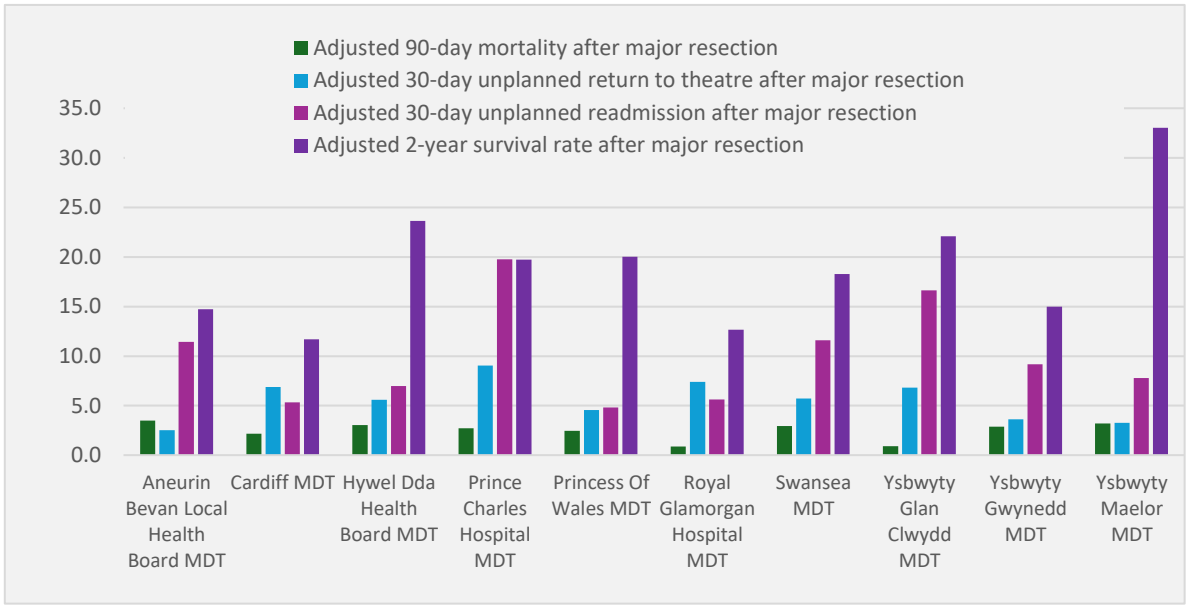
Patients having major resection:	Trust	Network	National
Number of patients in Audit	62	N/A	4251
Neoadjuvant therapy (%)	34	N/A	33
Circumferential resection margin: Recorded (%)	89	91	89

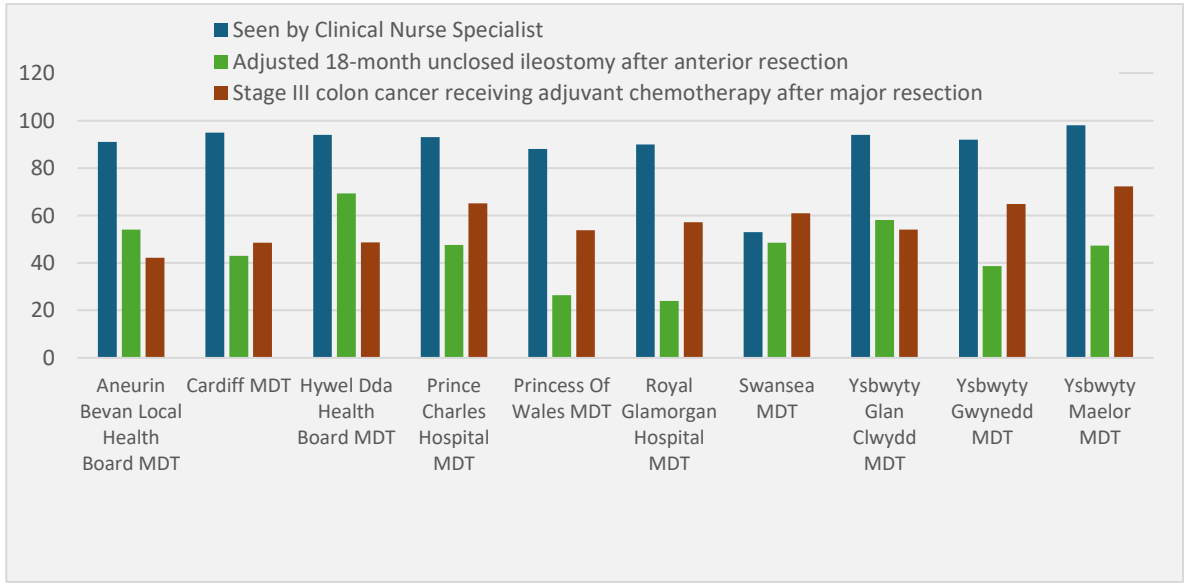
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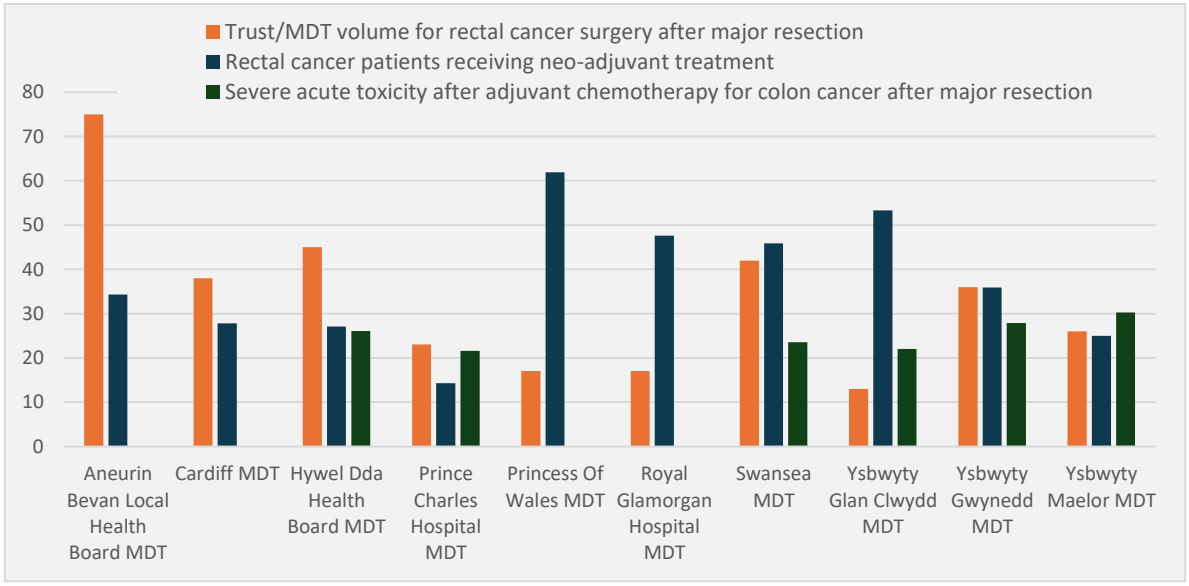
- > 80%
- 50 - 80%
- < 50%

Quality Improvements Targets – results for Welsh Health Boards









Conclusion and Risk

Assurance Level		
Significant	The project has mostly achieved the standards or criteria being audited against	Yes
Risk Level		
Minor	Single failure to meet internal standards/Minor implications for patient safety if unresolved	Yes
Has this audit been placed on a Risk Register (N/A if above risk is None)		**YES**

Key Success and Concerns

Report Successes:	
1	Good case ascertainment
2	Laparoscopic surgery > 50%
3	Quality assured rectal cancer resections
4	Comparable 2 year mortality rates
5	Good engagement with CNS

Report Concerns:	
1	Reversal of diverting loop ileostomy > 18/12
2	Unplanned readmissions within 30 days
3	Inadequate colonic stenting service

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Theatre space availability for cancers	Increase capacity	Theatre Group	6/12	
2	Colonic Stenting service	Audit colon stent results in last 24 months	K Swarnkar	6/12.	

	Report Recommendations:	S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	With future NBOCA reports utilising "gold standard" cancer registry data collected by the National Disease Registration Service (NDRS) in England, and the Wales Cancer Network in Wales, NDRS regional Data Liaison Managers should support hospitals/trusts/MDTs with coding, data entry, and quality assurance for the Cancer Outcomes and Services Data set (COSD). Data set items of focus include: • TNM Stage • ASA grade • Seen by Clinical Nurse Specialist (CNS) *Intended audience: NHS England, NDRS and* ***Public Health Wales***	Data collected on CANISC in real time in MDT	Cancer service-MDT coordinator		
2	In keeping with the NHS Workforce Plan, NHS England, Welsh Health Boards and Cancer Alliances should ensure everyone with bowel cancer has access to a clinical nurse specialist (CNS). NHS England, Welsh Health Boards and Cancer Alliances should investigate and address factors preventing patients' accessing a CNS. *Intended audience: NHS England,* ***Welsh Health Boards*** *and Cancer Alliances*	Already achieved in ABUHB. Prospective NBOCA data	CNS		
3	Cancer Alliances should participate and engage with the NBOCA/ Royal College of Surgeons of England quality improvement project to enable more timely reversal of ileostomy. ***Intended audience: Cancer Alliance***	Book theatre after WSCE to fix date.	Colorectal surgeon	12/12	
4	Cancer Alliances should monitor and investigate regional and institutional variation in rates of adjuvant chemotherapy following resection of stage III colon cancer and ensure evidence-based chemotherapy policies are in place. ***Intended audience: Cancer Alliances***	Velindre Cancer Centre	Dr H Williams	12/12	
5	Cancer Alliances should monitor and investigate regional and institutional variation in severe acute toxicity after adjuvant chemotherapy. Cancer Alliances should encourage the utilisation of appropriate risk stratification tools for severe acute toxicity including frailty scoring, and integration of geriatric expertise and rehabilitation into chemotherapy decision making. ***Intended audience: Cancer Alliances***	Velindre Cancer Centre	Dr H Williams	12/12	

Appendix 15

PUBLICATION DATE	TYPE	PROJECT NAME	FULL REPORT TITLE	CSEG
08/02/2024	NCEPOD	Child Health Clinical Outcome Review Programme	Child Health Clinical Outcome Review Programme - Testicular torsion report	**CSEG May 2024**
08/02/2024	Audit	GICAP-NBoCA - National Gastro Intestinal Cancer Audit Prog.	National Bowel Cancer Audit National Bowel Cancer Audit State of the Nation report	**CSEG Mar 2024**
08/02/2024	Audit	FFFAP - Falls & Fragility Fracture Audit	Fracture Liaison Service Database (FLSDB) Annual Report 2024: Improved FLS identification with gaps in monitoring: a call to action for national and regional planners (January-December 2022)	**CSEG May 2024**
08/02/2024	CORP	NCISH - Mental Health CORP	National Confidential Inquiry Into Suicide and Safety in Mental Health Annual Report 2024: UK patient and general population data 2011-2021	**MH&LD to provide update**
08/02/2024	CORP	NCISH - Mental Health CORP	The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) Suicide by people in contact with drug and alcohol services in the year prior to death report 2024: (cohort October 2021- September 2022)	**MH&LD to provide update**
11/01/2024	Audit	NDA - National Diabetes Audit (adults)	National Diabetes Audit 2021-22, Report 1: Care Processes and Treatment Targets, Detailed Analysis Report	**CSEG Mar 2024**
11/01/2024	Audit	SSNAP - Sentinel Stroke National Audit Programme	Sentinel Stroke National Audit Programme quarterly data only report (Jul-Sep 2023)	**Stroke Board**
11/01/2024	Audit	GICAP-NOGCA - National Gastro Intestinal Cancer Audit Prog. - National Oesophago Gastric Cancer Audit	National Oesophago-Gastric Cancer Audit State of the Nation report	**CSEG May 2024**
11/01/2024	Audit	NPCA - National Prostate Cancer Audit	National Prostate Cancer Audit State of the Nation report	**CSEG Mar 2024**

PUBLICATION DATE	TYPE	PROJECT NAME	FULL REPORT TITLE	CSEG
14/12/2023	Audit	NDA - National Diabetes Audit	National Diabetes Audit 2021-22, Young People with Type 2 Diabetes State of the Nation Report	**CSEG Mar 2024**
14/12/2023	Clinical Outcome Review Programme	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	A comparison of the care of Black and White women who have experienced a stillbirth or neonatal death - State of the Nation Report	**Family and Therapies to provide update**
14/12/2023	Clinical Outcome Review Programme	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	A comparison of the care of Asian and White women who have experienced a stillbirth or neonatal death - State of the Nation Report	**Family and Therapies to provide update**
14/12/2023	Audit	PICANet - Paediatric Intensive Care Audit	National Paediatric Critical Care Audit (PICANet) State of the Nation Report 2023	**Noah's Ark Cardiff and Vale UHB**
14/12/2023	NCEPOD	Medical and Surgical Clinical Outcome Review Programme	Consolidation Required: A review of the care provided to adults presenting to hospital with a diagnosis of community-acquired pneumonia	**QPS providing data to Sara Fairbairn**
09/11/2023	Audit	NVR - National Vascular Registry	National Vascular Registry - State of the Nation Report 2023 Results for patients who had vascular procedures during 2022 in NHS hospitals in England, Wales, Scotland and Northern Ireland	**CSEG Jan 2024**
08/06/2023			NVR Short Report: Impact of the COVID-19 pandemic on vascular surgery in the UK	
09/11/2023	Audit	SSNAP - Sentinel Stroke National Audit Programme	Sentinel Stroke National Audit Programme Annual Report 2023 Stroke care received between April 2022 to March 2023	**Stroke Board**

PUBLICATION DATE	TYPE	PROJECT NAME	FULL REPORT TITLE	CSEG
09/11/2023	Audit	NCMD - National Child Mortality Database	National Child Mortality Database Child Death Review Data Release: Year ending 31 March 2023	**Family and Therapies to provide update**
09/11/2023	Audit	FFFAP - Falls and Fragility Fracture Audit Programme	Inpatient falls and fractures – one chance to get it right The 2023 National Audit of Inpatient Falls report on 2022 clinical data	**Inpatient Falls Panel - to organised CSEG**
12/10/2023	Audit	NEIAA - National Early Inflammatory Arthritis Audit	National Early Inflammatory Arthritis Audit (NEIAA) State of the Nation Report 2023 - Summary report Data collection period: 1 April 2022 – 31 March 2023	**CSEG Jan 2024**
12/10/2023	Clinical Outcome Review Programme	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal, Newborn and Infant Clinical Outcome Review Programme: Saving Lives, Improving Mothers' Care State of the Nation Surveillance Report 2023 Surveillance findings from the UK Confidential Enquiries into Maternal Deaths 2019-21	**Family and Therapies to provide update**
12/10/2023	Clinical Outcome Review Programme	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal, Newborn and Infant Clinical Outcome Review Programme Saving Lives, Improving Mothers' Care State of the Nation Themed Report Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths from infection, neurological, haematological, respiratory, endocrine, gastrointestinal and general surgical causes 2019-21	**Family and Therapies to provide update**

PUBLICATION DATE	TYPE	PROJECT NAME	FULL REPORT TITLE	CSEG
12/10/2023	Clinical Outcome Review Programme	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal, Newborn and Infant Clinical Outcome Review Programme Saving Lives, Improving Mothers' Care State of the Nation Themed Report Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths from haemorrhage, amniotic fluid embolism and anaesthetic causes 2019-21 and morbidity following repeat caesarean birth	**Family and Therapies to provide update**
12/10/2023	Audit	NNAP - National Neonatal Audit Programme	National Neonatal Audit Programme (NNAP) - Summary report on 2022 data	**CSEG Nov 2023**
12/10/2023	Audit	NDA - National Diabetes Audit	National Diabetes Audit 2021-22, Report 1: Care Processes and Treatment Targets, Overview	**CSEG Nov 2023**
12/10/2023	Audit	NDA - National Diabetes Audit	National Diabetes Audit 2021-22, Type 1 Diabetes - Overview	**CSEG Nov 2023**
12/10/2023	Audit	NDA - National Diabetes Audit	National Pregnancy in Diabetes Audit 2021 and 2022 (01 January 2021 to 31 December 2022)	**CSEG Nov 2023**
14/09/2023	Audit	FFFAP - Falls and Fragility Fracture Audit Programme	15 Years of Quality Improvement: The 2023 National Hip Fracture Database report on 2022 (1 January 2022-31 December 2022)	**CSEG May 2023**
14/09/2023	Clinical Outcome Review Programme	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	MBRRACE-UK Perinatal Mortality Surveillance: UK Perinatal Deaths for Births from January to December 2021 - State of the Nation Report	**Family and Therapies to provide update**
10/08/2023	Audit	NAD - National Audit of Dementia	National Audit of Dementia - Care in General Hospitals 2022-2023 Round 5 Audit Report	**CSEG May 2024**
13/07/2023	Audit	NPDA - National Paediatric Diabetes Audit	NPDA: Report on hospital admissions of children and young people with diabetes, 2015-2020	**CSEG Jul 2023**

PUBLICATION DATE	TYPE	PROJECT NAME	FULL REPORT TITLE	CSEG
13/07/2023	Audit	NCMD - National Child Mortality Database	NCMD: Deaths of children and young people due to traumatic incidents: Vehicle Collisions, Drownings, Violence and Maltreatment and Unintentional Injuries	**Family and Therapies to provide update**
13/07/2023	Audit	Ep12 - National Audit of Seizures and Epilepsies	Epilepsy12 2023 combined organisational and clinical audits: Report for England and Wales Round 4, Cohort 4 (2020-22)	**Particially Participating**
13/07/2023	Audit	NACEL - National Audit of Care at the End of Life	NACEL: Fourth round of the audit (2022/23) report	**CSEG Jul 2024**
13/07/2023	Audit	NOGCA - National Oesophago-Gastric Cancer Audit	NOGCA short report: Socioeconomic differences in the impact of oesophago-gastric cancer on survival in England	**England only**
13/07/2023	NCEPOD	Medical and Surgical Clinical Outcome Review Programme	Making the Cut? A review of the care received by patients undergoing surgery for Crohn's Disease	**Unable to fully participate**
16/06/2023	NICOR	Heart Failure	National Heart Failure Audit (NHFA) 2021 Summary Report	**CSEG Sep 2023**
		MINAP	Myocardial Ischaemia National Audit Project (MINAP) 2021 Summary Report	**CSEG Sep 2023**
		PCI	National Audit of Percutaneous Coronary Interventions (NAPCI) 2021 Summary Report	**CSEG Mar 2024**
		Cardiac Rhythm	National Audit of Cardiac Rhythm Management (NACRM) Devices and Ablation 2021 Summary Report	**Unable to secure attendance at**
08/06/2023	CORP - Clinical Outcome Review Programme	Child Health & Medical and Surgical Clinical Outcome Review Programmes	NCEPOD: The Inbetweeners - A review of the barriers and facilitators in the process of the transition of children and young people with complex chronic health conditions into adult health services.	**Unable to fully participate**
12/04/2023	Audit	NLCA - National Lung Cancer Audit	NLCA: State of the Nation Report 2023	**CSEG May 2023**



GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Aneurin Bevan

Aneurin Bevan University Health Board

Aneurin Bevan University Health Board

Clinical  Plan

2024/2025

Clinical Standards and Effectiveness Group

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Introduction

The Health Board is committed to delivering safe and effective care to the population of Gwent.

Aneurin Bevan University Health Board uses Clinical Audit as part of a quality improvement cycle that measures concordance of care delivery with agreed local or national guideline defined standards. Following an audit, areas for improvement are identified and changed before being re-audited with the aim of improving reliability and outcomes of care.

Clinical audit is recognised by healthcare commissioners and regulators as an effective mechanism for providing assurance about the quality-of-care service users receive. The Health Board's Executive Committee are required by Welsh Government, to certify that they have effective systems, processes and procedures in place to monitor and audit compliance against clinical standards. This is managed in line with the Healthcare Quality Improvement Partnership (HQIP) National Clinical Audit and Patient Outcomes Programme (NCAPOP), which follows a 9-month publication schedule.

The Health Board's audit plan follows the National Clinical Audit 9-month rolling agenda and takes into consideration local audits at speciality and ward level across all sites across the Health Board.

What is Clinical Audit?

Clinical audit when conducted in accordance with best practice standards, provides assurance of compliance with clinical standards, identifies and minimises risk, waste, and variation in clinical practice from guideline defined standards of care. It also improves the quality of care and patient outcomes.

The results of clinical audit are one input into a wider Quality Management System designed to achieve continuous organisational learning and improvement in delivery of safe and effective care.

Before embarking on a clinical audit, it is important to ascertain whether the topic has been previously audited across the organisation to compare results.



Figure One: The audit cycle

Why is clinical audit important?

Clinical Audit provides the framework to improve the quality of patient care in a systematic way.

Benefits of clinical audit include:

- Promotes awareness of guideline defined standards of care.
- Provides opportunities for education and training.
- Builds relationships between clinicians, clinical teams, managers, and patients.
- Leads to improvements in service delivery and patient outcomes.

Who should be involved in clinical audit?

Everyone who is involved in patient care. If an audit has implications for clinicians or managers working in a particular area, they should be consulted at the planning stage. Clinical audit must also be supported by those who have the authority and commitment to see changes put into practice.

All Divisions within the Health Board should develop robust local audit plans. Topics for clinical audit should reflect national and/or local priorities or areas of concern e.g. Cancer Services or National Service Frameworks, or local priorities identified through incident reporting or introduction of best practice into local services.

Principles of the clinical audit plan

In developing the Aneurin Bevan University Health Board annual audit plan the following approach has been followed:

- Auditing of clinical standards, ensuring the quality of care that patients should be offered by health professionals and health services for a specific clinical condition or defined clinical pathway in line with current best evidence.
- Ensuring that variations in outcomes of care are understood and there is a coherent approach to the assessment of good practice.
- Ensuring that directorates participate in all National Clinical Audits (NCAs), National Confidential Enquiries (NCEPOD) and service reviews relevant to the services that it provides.
- National audits, which are not on NCAPOP, but which are included in the list for reporting as part of the Health Board's Quality Plan (e.g. Falls).
- NICE guidance and HTW adoption. Audit is not mandatory, but implementation and audit of NICE guidance can be subject to external review.
- Projects requiring re-audit after changes in practice.
- Ensuring that all clinical audit activity within directorates is registered.
- Working with clinicians, service managers, divisional governance and quality managers as well as clinical audit staff to ensure that the clinical audit programme for their directorate meets all clinical, statutory, regulatory, commissioning and other Health Board requirements.
- Ensure healthcare professionals are enabled to participate in clinical audit to satisfy demands of their relevant professional bodies (for example, for revalidation and professional development).
- Ensure the necessary resources, governance and organisational structures are in place to support engagement in audits, reviews and national registers included in the annual Plan.
- Ensure there is a formally recognised process for reviewing the organisations performance when reports are published. This review should 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

Aneurin Bevan University Health Board has a Clinical Audit Strategy 2022-2025 with four priorities:

Aneurin Bevan University Health Board has Four Priorities:

1. Scrutiny of national clinical audit performance with robust development, monitoring, and progression of Improvement plans

2. Divisions to identify clinical audits that allow scrutiny and assurance associated with quality and safety risk

3. Trainees are supported to participate in audits that support clinical governance

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

This can be read in conjunction with the Health Board's Clinical Audit Policy and The Quality Strategy.

Together these documents demonstrate how clinical audit will be developed, delivered and outcomes put into practice through service improvement.

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

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



Recommendations from Clinical Audit



1. Clinical Audit reports and outcomes identify recommendations for service improvement and QI work where data shows variation from standard of care
2. National and Local audit recommendations are reviewed by the ABUHB Clinical Lead
3. Risks are identified by clinical leads/teams, to ensure risks are escalated and recorded on risk register

The process of clinical audit is managed through the Clinical Standards and Effectiveness Group (CSEG). Steps are:

1. National report published
2. QPS audit team link with Clinical Lead/representative with audit results
3. Results presented at CSEG by Clinical Lead
4. SMART actions agreed against standards and/or good practice highlighted
5. Action plan placed on AMaT
6. Presented to Patient Safety and Quality Outcomes Committee (PQSOC)

Clinical Audit and AMaT

What is AMaT ?

Aneurin Bevan University Health Board has fully implemented AMaT (Audit Management and Tracking. AMaT is a software package designed to make auditing easier, faster, and more effective. Utilisation has been rolled out over the past 12-18 months, including training staff and ensuring AMaT utilisation at all steps of the audit cycle to allow assurance that audit results and outcomes are tracked by the organisation and teams are supported with the process.

Audit is a vital part of healthcare, helping to improve patient care, manage risk, and comply with reporting requirements. It can be time-consuming, labour-intensive, and often slow to deliver results and actions. AMaT has enabled more control over audit activity. The standardised reporting template has been utilised in the system to enable reporting at CSEG. It has provided real-time insight and reporting for clinicians, wards and the quality and patient safety audit department. It is being used for completing local audits and tracking actions and improvement plans for National Clinical Audit.

AMaT has been straight forward to implement and presented to Divisions as part of the Clinical Audit Strategy. Data can be inputted and accessed in real time on a smartphone, tablet, laptop or desktop computer, giving healthcare staff increased flexibility and mobility - and more time to spend with patients.

The tracking of audits has been made easier with users being able to allocate SMART actions across their teams and provides data results instantly, numerically or graphically. Key successes, concerns, risk and assurance can also be recorded.

Clinical Audit Plan

Aneurin Bevan University Health Board's Clinical Audit Plan reflects national and local drivers for quality improvement.

The 'Plan' is used by the Quality and Patient Safety Team (QPS) to have a defined map of publications throughout the year and can organise these in line with the Clinical Audit Strategy:

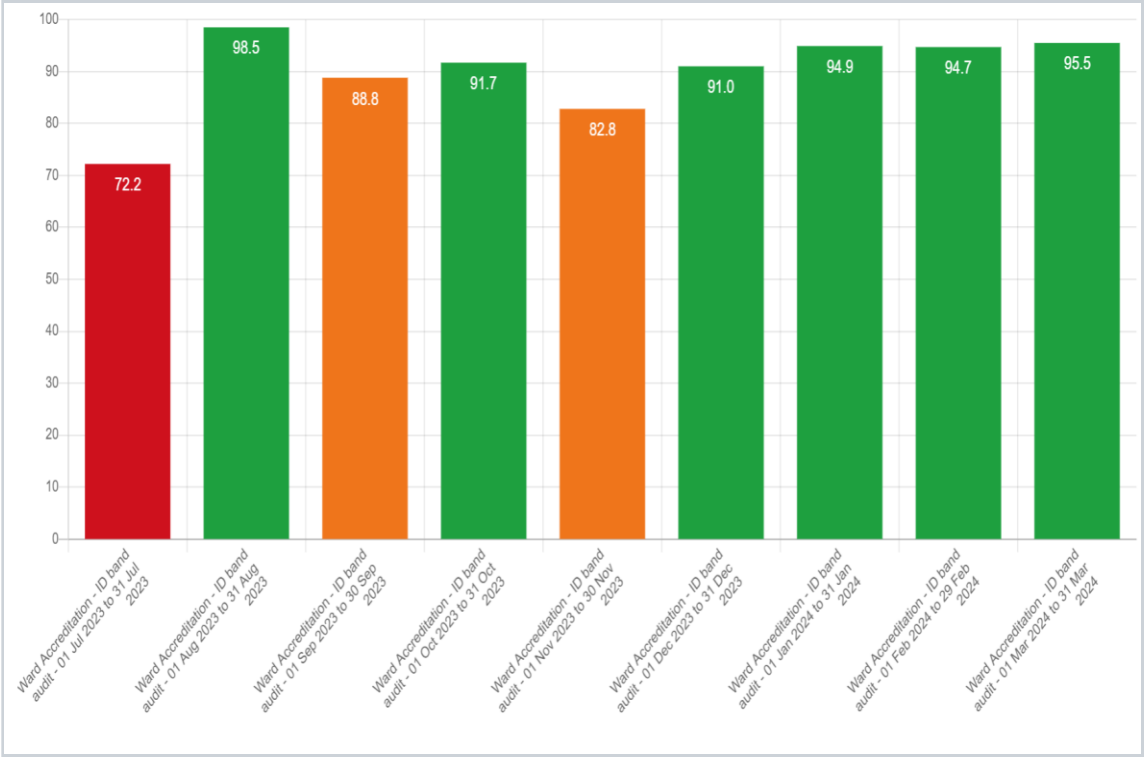
- The Clinical Audit Plan will be added to and refined annually as Clinical Audit processes develop in the Health Board.
- It provides a prioritised list of planned clinical audit activity.
- The National Clinical Audit and Patient Outcomes Programme (NCAPOP) commissioned by Healthcare Quality Improvement Partnership (HQIP) and NHS Wales National Clinical Audit Outcome Review Plan (NCAOPR) is published on a rolling nine-month programme.
- The current audit plan includes audit publication dates scheduled between April 2024 & April 2025.
- All National Clinical Audits (NCA's) will be managed in AMaT.
- The standardised AMaT audit report template will be used, ensuring consistency of reporting to PQSOC.
- Local audits must be registered via AMaT to ensure results are visible.
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) participation is included in our plan (The NCEPOD process is designed to assist in improving standards of care by undertaking confidential reviews of patient care and publishing national recommendations in areas studied).

As defined in Priority 2 - Divisions will identify clinical audits that allow scrutiny and assurance associated with quality and safety risk

Divisions have been identifying audits that provide assurance and any improvement work associated with areas of priority including:

- Serious Incidents
- Poor Clinical Outcomes
- New Guidance
- Mortality Reviews / M&M

All audits are being registered on AMaT. The system is being used to build proformas and undertake the audit. Results are presented as dashboards – providing visual and easy to understand data/charts. Here are examples of local audits on AMaT relating to ward accreditation and IP&C.



	Main frequency	Auditor	Compliance and submissions over last 3 audits			Current	Due in	Progress	Data	Drafts	Plan	Overdue actions	Manage
Environmental	M	Ward Staff	A 84.9% (1/1)	G 91.8% (1/1)	G 90.7% (1/1)		26 days	Click to audit	-	-			ACTIONS
Get Up, Get g.	M	Nursing Staff	R 66.7% (1/1)	G 100.0% (1/1)	G 100.0% (1/1)		26 days	Click to audit	-	-			ACTIONS
Hand Hygiene	M	Ward Manager	G 100.0% (20/20)	G 100.0% (20/20)	G 100.0% (20/20)		26 days	Click to audit	-	-			ACTIONS
Hospital t	M	Nursing Staff	R 71.4% (8/8)	R 69.9% (8/8)	A 78.6% (8/8)		26 days	Click to audit	-	-			ACTIONS

Appendix One – National Clinical Audit and Outcome Review Plan

This is published on a rolling nine-month Programme and will be updated monthly on the Quality and Patient Safety Clinical Audit Intranet Page. National Clinical Audit and Patient Outcomes Programme (NCAPOP) commissioned by Healthcare Quality Improvement Partnership (HQIP) and NHS Wales National Clinical Audit Outcome Review Plan (NCAOPR). Publication notification date 11th April 2024

PUBLICATION DATE	TYPE	PROJECT NAME	FULL REPORT TITLE	CSEG
11/04/2024	NCA	SSNAP - Sentinel Stroke National Audit Programme	Sentinel Stroke National Audit Programme quarterly data only report (Oct-Dec 2023)	**Stroke Board**
11/04/2024	Audit	NLCA - National Lung Cancer Audit	National Lung Cancer Audit State of the Nation report (01/01-31/12/2022 data; Eng & Wales)	**CSEG Jul 2024**
11/04/2024	Audit	NELA - National Emergency Laparotomy Audit	National Emergency Laparotomy Audit State of Nation report 2024	**CSEG May 2024**
09/05/2024	NCA	NDA - National Diabetes Audit (adults)	National Diabetes Foot Care Audit (NDFA) State of the Nation report, 01/04/2021-31/03/2022 TBC; Eng & Wal.	**CSEG Jul 2024**
13/06/2024	NCA	NRAP - National Respiratory Audit Programme (was NACAP)	National Respiratory Audit State of the Nation report	**CSEG Jul 2024**
11/07/2024	NCA	NDA - National Diabetes Audit (adults)	National Diabetes Inpatient Safety Audit (NDISA) State of the Nation report, May 2018 - Oct 2023; Eng & Wal.	**CSEG Jul 2024**
11/07/2024	CORP	Medical and Surgical Clinical Outcome Review Programme	Medical and Surgical Clinical Outcome Review Programme - Endometriosis report	**CSEG Oct 2024**
11/07/2024	NCA	Epilepsy12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	Epilepsy12 State of the National report, England and Wales (2021-23)	**Particially Participating**
08/08/2024	NCA	NRAP - National Respiratory Audit Programme (was NACAP)	National Respiratory Audit Programme Primary Care Report (cohort TBC)	**CSEG Sep 2024**
08/08/2024	NCA	NAD - National Audit of Dementia	National Audit of Dementia: Memory Assessment Services Spotlight Report	**Dementia Team ONLY**

Appendix One – National Clinical Audit and Outcome Review Plan

PUBLICATION DATE	TYPE	PROJECT NAME	FULL REPORT TITLE	CSEG
12/09/2024	NCA	NatCan - National Cancer Audit Collaborating Centre (was NCACC)	National Primary Breast Cancer Audit (NaoPri) - State of the Nation	**CSEG Dec 2024**
12/09/2024	NCA	NatCan - National Cancer Audit Collaborating Centre (was NCACC)	National Metastatic Breast Cancer Audit (NaoMe) - State of the Nation	**CSEG Dec 2024**
12/09/2024	NCA	NatCan - National Cancer Audit Collaborating Centre (was NCACC)	National Ovarian Cancer Audit (NOCA) - State of the Nation	**CSEG Dec 2024**
12/09/2024	NCA	NatCan - National Cancer Audit Collaborating Centre (was NCACC)	National Pancreatic Cancer Audit (NPaCA) - State of the Nation	**CSEG Dec 2024**
12/09/2024	NCA	NatCan - National Cancer Audit Collaborating Centre (was NCACC)	National Non-Hodgkin Lymphoma Audit (NNHLA) - State of the Nation	**CSEG Dec 2024**
12/09/2024	NCA	NatCan - National Cancer Audit Collaborating Centre (was NCACC)	National Kidney Cancer Audit (NKCA) - State of the Nation	**CSEG Dec 2024**
12/09/2024	NCA	FFFAP - National Falls & Fragility Fracture Audit Programme	National Hip Fracture Database State of the Nation 2024	**CSEG Oct 2024**
10/10/2024	NCA	FFFAP - National Falls & Fragility Fracture Audit Programme	National Audit of Inpatient Falls State of the Nation 2024	**Falls and Bone Health Group**
10/10/2024	NCA	NEIAA - National Early Inflammatory Arthritis Audit	National Early Inflammatory Arthritis Audit State of the Nation 2024 Annual Report	**CSEG Jan 2025**

Appendix One – National Clinical Audit and Outcome Review Plan

PUBLICATION DATE	TYPE	PROJECT NAME	FULL REPORT TITLE	CSEG
10/10/2024	NCA	NPDA - National Paediatric Diabetes Audit	National Paediatric Diabetes Audit PREMS report 2024 (24/07/2023 - 23/01/2024)	**Data to Clinical Lead ONLY**
10/10/2024	NCA	NNAP - National Neonatal Audit Programme	National Neonatal Audit Programme 2024 report	**CSEG Jan 2025**
10/10/2024	CORP	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal, Newborn and Infant Clinical Outcome Review Programme Saving lives, improving mothers care report	**Family and Therapies to provide update**
14/11/2024	NCA	NRAP - National Respiratory Audit Programme (was NACAP)	National Respiratory Audit Programme Combined Organisational Report	**CSEG Jan 2025**
14/11/2024	NCA	NVR - National Vascular Registry	National Vascular Registry state of the nation report 2024	**CSEG Jan 2025**
14/11/2024	NCA	SSNAP - Sentinel Stroke National Audit Programme	Sentinel Stroke National Audit Programme State of the Nation 2024	**Stroke Board**
14/11/2024	CORP	Medical and Surgical Clinical Outcome Review Programme	Medical and Surgical Clinical Outcome Review Programme: End of Life Care report 2024	**CSEG Jan 2025**
14/11/2024	N/A	NCMD - National Child Mortality Database	National Child Mortality Database Child Death Reviews Data year ending 31/03/2024	**Family and Therapies to provide update**

Corporate Audits

The Clinical Audit Team facilitate audits throughout the year. These can be scheduled in advance with defined dates to be undertaken, or triggered by governance issues that arise during the year which require further investigation. The Clinical Audit Team assist with Health Board specific audits.

These audits are all managed on AMaT and will be accomplished with the support of a Clinical Lead within that area of expertise.

All audit results will go through the Clinical Standards and Effectiveness Group, with the same process as for National Audit and these are documented in the same way, providing assurance, successes and concerns and action plans which will be monitored.

Audit Title:		**Clinical Lead:**	
Rationale:			
Objectives:			
CSEG date:			

Report Successes: (to be completed by the Clinical Lead)
Report Concerns: (to be completed by the Clinical Lead)

Assurance level	**Description**	**Select**
Risk level	**Description**	**Select**

Report Recommendations: (national)	**S.M.A.R.T Actions:**	**Responsible:** **Due Date:** **Progress:**

Current Corporate Audits

DNACPR
Consent
Quality of notes audit
Mortality review audits

Local Audits to be completed in 2024/25

Urgent Care Audits
Time to ECG from book in in chest pain and time seen by Dr
Time to XR from request
Non-essential cannulations
Asthma management and documentation in >16yo
Trauma call activation and who attended
Time to formal CT/MRI report
Time of referral to time seen by medical team
WP10 prescription and documentation
Seizure checklist
Time of referral to time seen by surgical team

Dermatology
Hidradenitis audit
Camouflage clinic audit
Paediatrics high-cost drugs

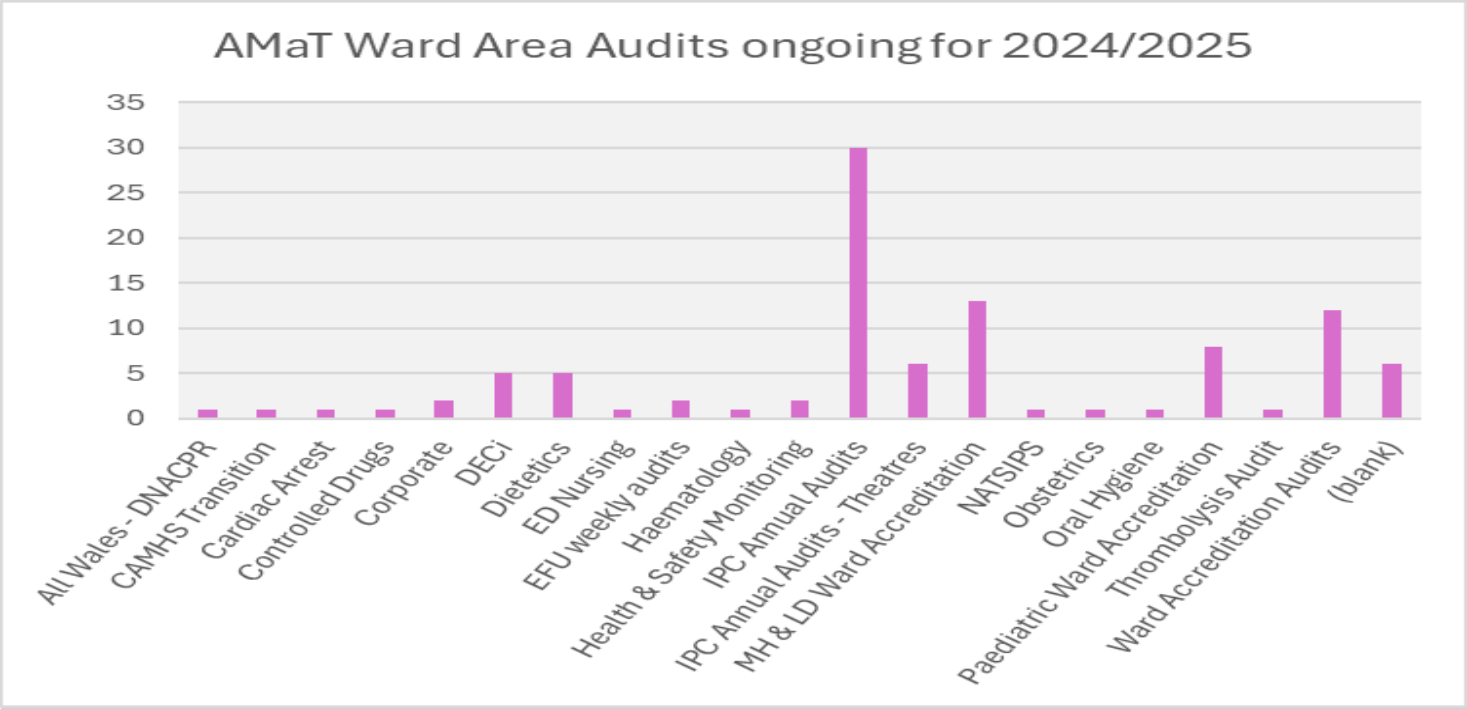
Medicine	
DECI	PSAAG audit
FOC	D2RA audit
H&CS	Fridge temperatures
1pt 1 day	Resus trolley
Infection control dashboard	Falls
Hand hygiene	Diabetic
Call bells	Continence
Wrist bands	Nutrition and hydration
Enhanced care	Fluid balance audit
Dementia audit	Care flow audits
Kings fund audit	Fridge temperatures
Nutritional audit	Resus trolley
Ward assurance audits	Being implemented

The above audits are listed with the divisions as a plan going forward into 2024/2025

Local Audit on AMaT

Local audits are managed in AMaT. Audit activity is shown in the tables below:

Currently there are 101 ward based audits listed for 2024/2025:



Action Status	Count
Action no longer relevant	24
Fully Complete	1335
New	284
Overdue	608
Partially complete	12
Partially complete (Overdue)	41
Unable to Complete	14
Total	**2318**

As soon as the audit is completed, actions can be allocated if the audit shows a need for improvement. Once completed and signed off there is an audit trail of the action(s). The current action log in AMaT ward area can be seen here, with 1,335 completed action s out of a total of 2,318.

Conclusion

There has been a large amount of audit activity added to AMaT daily since its initiation in June 2022. The Clinical Audit Team are on hand to provide training structured to the needs of the users. To date ~600 staff have received bespoke training and the systems holds more than 1300 users.

The implementation of AMaT improved the efficiency and accountability of local audits. It has allowed teams to analyse audit to identify and evidence good practice and areas needing improvement which can be shared via management teams.

Planning for National Clinical Audits, which have set publication dates, is easier than planning local audit. Audit can be challenging for clinical teams when there are competing priorities of managing service pressures and focusing on delivering patient focused services.

Future work will ensure learning from audit and review is shared across the organisation and communicated to staff and patients.

Patient experience, quality, and safety is at the centre of our work to secure improvements in the quality of care and services we deliver and to improve outcomes for the population we serve. Clinical audit is an important component of our EFFECTIVE commitments over the next three years to enable delivery of the Duty of Quality, as mapped to the six domains of quality. This will support the delivery of a sustainable and resilient health and care system in the wake of the Covid-19 pandemic.



- **Patient Safety Lunch & Learn, Monday 24th June 2024**
- **Patient and Public Involvement Lunch & Learn, Tuesday 25th June 2024**
- **Healthcare Inequalities Lunch & Learn, Wednesday 26th June 2024**
- **Influencing Change Lunch & Learn, Thursday 27th June 2024**
- **Sustainability Lunch & Learn, Friday 28th June 2024.**

Agenda Item:

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	21 May 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Standards of Behaviour Policy and Framework
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Bryony Codd, Head of Corporate Governance

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report presents, for comment, the revised Standards of Behaviour Framework and Policy for the Health Board.

The Health Board's Standing Orders state that:

"The Board must adopt a set of values and standards of behaviour for the LHB that meets the requirements of the NHS Wales Values and Standards of Behaviour framework. These values and standards of behaviour will apply to all those conducting business by or on behalf of the LHB, including Board members, LHB officers and others, as appropriate. The framework adopted by the Board including the Health Boards Values and Standards of Behaviour Framework and Policy for Standards of Business Conduct will form part of these SOs."

Cefndir / Background

The Standards of Behaviour Policy enables Aneurin Bevan University Health Board (ABUHB) to ensure that its Employees and Independent Members practice the highest standards of conduct and behaviour. The policy sets out the expectations

required and provides supporting guidance so that all Employees and Independent Members are supported in delivering that requirement.

The "Seven Principles of Public Life", or the "Nolan Principles", form the basis of the Standards of Behaviour requirements for Health Board employees and Independent Board Members. These are:

- **Selflessness** – Individuals should act solely in terms of the public interest. They should not do so in order to gain financial orother benefits for themselves, their family or friends.
- **Integrity** – Individuals should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in theperformance of their official duties.
- **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, recommending individuals for rewards and benefits, choices should be made on merit.
- **Accountability** – Individuals are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate for their position.
- **Openness** – Individuals should be as open as possible about all the decisions and actions they take. They should give reasons fortheir decisions and restrict information only when the wider public interest clearly demands it.
- **Honesty** – Individuals have a duty to declare any private interests relating to their duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
- **Leadership** – Individuals should promote and support theseprinciples by leadership and example.

In support of these principles, Independent Board Members and all employees must be impartial and honest in the way that they go about their day-to-day functions. They must remain beyond suspicion at all times. They can achieve the "Seven Principles"above by:

- Ensuring that the interests of patients remain paramount.
- Being impartial and honest in the conduct of their official business.
- Using public funds to the best advantage of the service and the patients, always seeking to ensure value for money.
- Not abusing their official position for personal gain or to benefit family or friends.
- Not seeking advantage or to further private business or other interests in the course of their official duties.
- Not seeking or knowingly accepting, preferential rates or benefits in kind for private transactions carried out with companies, with which they have had, or may have, official dealings on behalf of the Health Board.

The Standards of Behaviour Policy re-states and builds on the provisions of Section 7, Values and Standards of Behaviour, of the Health Board's Standing Orders. It re-emphasises the commitment of the Health Board to ensure that it operates to the highest standards, the roles and responsibilities of those employed by the Health Board and the arrangements for ensuring that declarations of interests, gifts, hospitality, honoraria and sponsorship can be made.

The Policy is supported by a short guide on the Standards of Behaviour Framework that provides a summary of expected conduct. This Framework is intended to

compliment the various Professional Codes of Conduct relevant to Employees of the Health Board.

Asesiad / Assessment

The Health Board's current Standards for Business Conduct Policy was approved by the Audit Committee in October 2019 and, although is now overdue for a review, remains the extant policy for the organisation.

A key corporate governance priority within the IMTP is to further strengthen mechanisms for recording and reporting declarations of interest, gifts, hospitality and sponsorship. The revised policy (Attachment One) is based on that adopted by a number of Health Board's and expands of the current policy, providing more explicit guidance on declaring interests, gifts and hospitality, and now includes honoraria and sponsorship.

In support of the revised policy, work will be undertaken to develop a new sharepoint site which will include support and guidance for implementing the policy, and utilise Microsoft forms for completing declarations, which will automatically populate the relevant register.

In line with Standing Orders, the Audit, Risk and Assurance Committee will continue to review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests, and for gifts, hospitality and sponsorship. This will be undertaken bi-annually.

The Policy is being presented to the Audit, Risk and Assurance Committee for review as part of the consultation process prior to submission to the Board for approval in July. The Policy will also be considered by the Workforce and OD Policy Group and submitted to the EQIA Group for assessment.

Argymhelliad / Recommendation

The Committee is asked to review and comment on the Standards of Behaviour Framework and Policy for the Health Board.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.

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

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

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

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

Standards of Behaviour Policy

(incorporating Declarations of Interest, Gifts, Hospitality, Sponsorship and Honoraria)

Lead Author (s)	Bryony Codd, Head of Corporate Governance
Lead Executive	Rani Dash, Director of Corporate Governance
Division/Department	Corporate Governance
Reference	Health Board wide: ABUHB/Corporate/0258
Applies to (delete as appropriate)	Health Board Wide
Approving Forum	Board
Date Approved	Insert date in full dd/mm/yyyy
Review Date	Insert date in full dd/mm/yyyy

Version Control (latest version number to be listed first):

Version No	Approved	Author
05		

Policy on a Page: Key Messages

Aim:

This policy outlines the arrangements in ABUHB to ensure that staff comply with the requirements for recording and declaring potential conflicts of interest and handling of gifts, hospitality, honoraria and sponsorship (even if these are declined).

Summary of key changes (for revised documents only)

This is a re-write and expansion of the former Business Conduct Policy, to provide more explicit guidance on declaring interests, gifts and hospitality, and now includes honoraria and sponsorship.

Key Requirements:

How to declare and record potential conflicts of interest.

Ensure you are not in a position where you (or your close family's) private interests and NHS duties may conflict.

Seek your managers permission before taking any outside work, in accordance with employment terms and conditions.

Declare any offers of gifts, hospitality or sponsorship using the appropriate forms

Obtain permission before accepting any commercial sponsorship or hospitality.

If in doubt declare it!

Target Audience:

All employees and Board Members.

Training:

No specific training requirements however, awareness raising sessions will be held with managers.

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1. Introduction/Overview

The Standards of Behaviour Policy enables Aneurin Bevan University Health Board (ABUHB) to ensure that its Employees and Independent Members practice the highest standards of conduct and behaviour. This policy sets out the expectations required and provides supporting guidance so that all Employees and Independent Members are supported in delivering that requirement.

2. Scope

This Policy is applicable across the whole of the Health Board. It applies to all Employees and Independent Board Members. The term "Employees" includes all those who have a contract of employment or honorary contract with the Health Board.

3. Background

The Welsh Government's *Citizen-Centred Governance Principles* apply to all public bodies in Wales. These principles integrate all aspects of governance and embody the values and standards of behaviour expected at all levels of public services in Wales.

"Public service values and associated behaviours are and must be at the heart of the NHS in Wales"

ABUHB is strongly committed to being value-driven, rooted in the Nolan principles and high standards of public life and behaviour, including openness, customer service standards, diversity and engaged leadership.

The Board expects all Independent Board Members and Employees to practice high standards of corporate and personal conduct, based on the recognition that the needs of patients must come first.

The "Seven Principles of Public Life", or the "Nolan Principles", form the basis of the Standards of Behaviour requirements for Health Board employees and Independent Board Members. These are:

- **Selflessness** – Individuals should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or friends.
- **Integrity** – Individuals should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in theperformance of their official duties.
- **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, recommending individuals for rewards and benefits, choices should be made on merit.
- **Accountability** – Individuals are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate for their position.

- **Openness** – Individuals should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands it.
- **Honesty** – Individuals have a duty to declare any private interests relating to their duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
- **Leadership** – Individuals should promote and support these principles by leadership and example.

In support of these principles, Independent Board Members and all employees must be impartial and honest in the way that they go about their day-to-day functions. They must remain beyond suspicion at all times. They can achieve the "Seven Principles"above by:

- Ensuring that the interests of patients remain paramount.
- Being impartial and honest in the conduct of their official business.
- Using public funds to the best advantage of the service and the patients, always seeking to ensure value for money.
- Not abusing their official position for personal gain or to benefit family or friends.
- Not seeking advantage or to further private business or other interests in the course of their official duties.
- Not seeking or knowingly accepting, preferential rates or benefits in kind for private transactions carried out with companies, with which they have had, or may have, official dealings on behalf of the Health Board.

This Policy re-states and builds on the provisions of Section 7, Values and Standards of Behaviour, of the Health Board's Standing Orders. It re-emphasises the commitment of the Health Board to ensure that it operates to the highest standards, the roles and responsibilities of those employed by the Health Board and the arrangements for ensuring that declarations of interests, gifts, hospitality, honoraria and sponsorship can be made.

The Policy is supported by a short guide on the Standards of Behaviour Framework (see **Appendix 1**) that provides a summary of expected conduct. This Framework is intended to compliment the various Professional Codes of Conduct relevant to Employees of the Health Board.

The impact of other Health Board policies which should be considered by staff include:

- The Counter Fraud Bribery and Corruption policy
- Charitable Funds Financial Control Procedure
- Counter Fraud, Bribery and Corruption Policy
- Raising Concerns (Whistleblowing)
- Personal Relationships at Work Policy

4. The Bribery Act 2010

The Bribery Act 2010 came into force on 1st July 2011.

It reformed the criminal law of bribery, making it easier to tackle this offence proactively in both the public and private sectors. It is intended to respond to the extremely broad range of ways in which bribery can be committed by providing robust offences, enhanced sentencing powers, and wide jurisdictional powers.

Broadly, the Act defines bribery as:

"Giving or receiving a financial or other advantage in connection with the "improper performance" of a position of trust, or a function that is expected to be performed impartially or in good faith"

The Bribery Act 2010 abolished all existing UK Anti-Bribery Laws and replaced them with a suite of new offences markedly different to what has gone before.

The Bribery Act 2010 made it a criminal offence to "give, promise or offer a bribe and to request, agree to receive or accept a bribe either at home or abroad". The maximum penalty for bribery is up to 10 years imprisonment, with an unlimited fine. In addition, the Act introduced a 'corporate offence' of failing to prevent bribery by the organisation not having adequate preventative procedures in place. An organisation may avoid conviction if it can show that it had such procedures and protocols in place to prevent bribery. The 'corporate offence' is not a standalone offence, but always follows from a bribery and/or corruption offence committed by an individual associated with thecompany or organisation in question.

Bribery does not have to involve cash or an actual payment exchanging hands and can take many forms such as a gift, lavish treatment during a business trip or tickets to an event.

Some simple examples follow:

- Bribery in order to secure or keep a contract.
- Bribery to secure an order.
- Bribery to gain any advantage over a competitor.
- Bribery of a local, national or foreign official to secure a contract.
- Bribery to turn a blind eye to a health and safety issue or poor performance or substitution of materials or false labour charges.
- Bribery to falsify an inspection report or obtain a certificate.

5. Aim

The aim of this Policy is to ensure that arrangements are in place to support employees to act in a manner that upholds the Standards of Behaviour Framework as well as setting out specific arrangements for the appropriate declarations of interests and acceptance/refusal and record of offers of Gifts, Hospitality or Sponsorship. The Policy also aims to capture public acceptability of behaviours of those working in the public sector so that the Health Board can be seen to have exemplary practice in this regard.

ABUHB is committed to ensuring that its employees and Independent Members practice the highest standards of conduct and behaviour. This policy sets out those expectations and provides supporting guidance so that all employees and Independent Members are supported to deliver this requirement.

6. Roles and Responsibilities

Chief Executive

The Chief Executive is the "Accountable Officer" with overall responsibility for ensuring that the Health Board operates efficiently, economically and with probity. The Chief Executive will ensure a policy framework is set and that arrangements are in place to support the delivery of that framework.

Director of Corporate Governance

The Director of Corporate Governance has delegated responsibility for ensuring that the Health Board is provided with competent advice and support regarding the contents and application of this Policy and the Standards of Behaviour Framework. They will ensure that:-

(i) A Register of Interests is established and maintained as a formal record of interests declared by Employees and Independent Board Members. The Register will include details of Directorships, pecuniary (financial) and non-pecuniary interests in organisations that may have dealings with the NHS and membership of professional committees and third sector bodies. Where relevant it will also include details of interests of close family members or civil partners.

(ii) In addition, all staff employed in areas deemed specific 'high risk', as per Table 1 below, will be asked to complete a Declaration of Interest form. For the purpose of defining high risk, the Health Board considers this to include those whose role necessarily brings them into contact with external companies, contractors or suppliers, those who are able to initiate orders or those who are budget holders and strategic decision makers. This includes any interests that may influence, or be perceived to influence, the member of staff's judgment in the course of undertaking their duties whilst working for ABUHB.

Table One:

Independent Members	Annually
Executive Directors	Annually
Associate Members	Annually
Staff in specified 'high risk' areas	
Staff at Band 8a and above	Annually
Research & Development Staff*	Annually
Procurement Staff*	Annually
Pharmacy Staff*	Annually
Informatics Staff*	Annually
Estates and Facilities Staff*	Annually

*whose role necessarily brings them into contact with external companies, contractors or suppliers, those who are able to initiate orders or those who are budget holders

Note: It is the individual employee's responsibility to make a declaration should their circumstances change within these timescales.

(iii) A Register of Gifts, Hospitality, Honoraria and Sponsorship, whether accepted or declined, is maintained.

(iv) Appropriate information from the Registers of Declarations of Interests and Gifts, Hospitality, Honoraria and Sponsorship is published on the Health Board Website in accordance with the requirements of the Freedom of Information Act.

(v) Reports detailing the content of the Registers of Declarations of Interests and Gifts, Hospitality, Honoraria and Sponsorship and the effectiveness and adequacy of the arrangements in place will be provided to the Audit, Risk and Assurance Committee on an annual basis.

(vi) The form that Employees should complete when making a Declaration of Interest or when advising if gifts, hospitality, sponsorship or honoraria have been accepted or declined are included as **Appendix 2** and **Appendix 3**.

Chair
The Chair should:

- Ensure that Independent Board Members are aware of the requirements contained within this Policy and the Standards of Behaviour Framework.

- Ensure that the Audit, Risk and Assurance Committee review the adequacy of arrangements for managing Declarations of Interest and Gifts and Hospitality.

- Lead by example and ensure that they personally declare any relevant interest or the offer of gifts, hospitality or sponsorship.

- Approve (or not) the acceptance of gifts, hospitality and sponsorship that have been offered to Independent Board Members **PRIOR** to the event.

Executive, Assistant and Divisional Directors
Directors must ensure that:

- Employees are aware of the requirements contained within this Policy and the Standards of Behaviour Framework.

- Lead by example and ensure that they personally declare any relevant interest or the offer of gifts, hospitality or sponsorship.

- They review the contents of the Registers of Declarations of Interest and Gifts, Hospitality and Sponsorship on an annual basis to assist with the verification of the accuracy of the information contained within it.

- During periods of annual leave and prolonged absence they will ensure that they delegate the responsibilities to their relevant deputy.

Line Managers / Departmental Managers
Line/Departmental Managers (with budget management responsibilities) will:

- Lead by example and ensure that they personally declare any relevant interest or the offer of gifts, hospitality or sponsorship.

- Ensure that Employees are aware of the requirement to follow and comply with the Policy and Standards of Behaviour Framework. The Standards of Behaviour Framework will be discussed at Individual Performance Reviews, Consultant Appraisals and as part of the Consultant Job Plan Reviews as appropriate.

- Approve (or not) the acceptance of gifts, hospitality and sponsorship that have been offered within their Directorate **PRIOR** to the event.

- Support their Employees in the application of the Policy and the Standards of Behaviour Framework, seeking advice from the Director of Corporate Governance if required.

"Relevant interests" will include:-

(a) Directorships, including Non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.

(b) Ownership or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the Health Board. This includes shareholdings, debentures or rights where the total nominal value is £5,000 or one hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less.

(c) A personal or departmental interest in any part of the pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team.

(d) Sponsorship or funding from a known NHS supplier or associated company/subsidiary.

(e) A position of authority in a charity or voluntary body in the field of health and social care.

(f) Any other connection with a voluntary, statutory, charitable orprivate body that could create a potential opportunity for conflicting interests.

(g) Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.

It is recommended that where there is doubt, a declaration of interest should be made.

Employees and Independent Board Members
All Employees and Independent Members, including those on Honorary Contracts, will ensure that they:

- Understand this Policy and the Standards of Behaviour Framework, consulting their line manager if they require clarification.

- Declare to the Health Board for recording in the Register of Interests any relevant interests:
    - At the commencement of employment
    - Whenever a new interest arises, and
    - If asked to do so at periodic intervals by the Health Board.

- Inform patients and their relatives as appropriate, when referring them for treatment, investigation, or any aspect of their care if they have a material interest in an organisation to which they plan to refer a patient. The fact that the patient has been informed must be recorded appropriately.

- Verbally declare any relevant interest when a potential for conflict arises e.g. at Board and committee meetings, during procurement processes.

- Declare to the Health Board for recording in the Register of Gifts, Hospitality and Sponsorship any offer of a gift, hospitality or sponsorship which requires recording.

- Obtain permission from their line manager[1] before accepting gifts, hospitality or sponsorship which require recording.

- Observe the Standing Orders, Standing Financial Instructions and procurement policies and procedures of the Health Board.

- Where employees or Independent Members wish to engage in any outside employment which may affect their contractual obligation to ABUHB, they must first discuss it with their Line Manager. This will ensure that their position in ABUHB is not compromised. Agreement to such outside employment will not be unreasonably refused.

[1] must have budget management responsibilities

It is the responsibility of all Employees and Independent Members to ensure they are not placed in a position that risks, or appears to risk, conflict between their private interest and their ABUHB duties. This responsibility applies to all ABUHB staff, including those who commit resources directly, by ordering goods or services, and those who do so indirectly.

Procurement Department

Where an Employee is requested to participate in an ABUHB procurement process and has not previously completed a Declaration of Interest Form, they will be asked to do so prior to participating, or asked to reaffirm their interests and to confirm that there are no other relevant interests that should be declared.

The procurement lead will scrutinise such individual Declarations of Interest to ensure that there is no opportunity for any conflicts of interest.

The NHS Wales Shared Services Partnership (NWSSP) will ensure that all procurement staff complete declaration of interest forms in line with their procedures. NWSSP will advise ABUHB, through the Director of Corporate Governance, of any such interests impacting on ABUHB services.

Whilst individual staff must not seek or accept preferential rates or benefits in kind for private transactions carried out with which they have, or may have, official dealings with on behalf of ABUHB, this does not apply to concessionary agreements negotiated with companies by NHS management, or by recognised staff interests on behalf of all staff, for example, NHS staff benefits schemes.

All staff in contact with suppliers and contractors, particularly if authorised to sign purchase orders or place contracts for goods, materials or services, shall adhere to accepted professional standards i.e. the NHS Wales Shared Services Partnership Procurement Policy and the Standing Orders and Standing Financial Instructions of ABUHB.

Directors and Senior Managers should ensure that no special favour is shown to current or former staff or their close relatives or associates in awarding contracts to private or other businesses operated by them or employing them in a senior or relevant managerial capacity.

Contracts may be awarded to such business where they are won in fair competition against other tenderers, but care must be taken to ensure that the selection process is conducted impartially, and that staff who are known to have a relevant interest play no part in the selection.

7. Register of Interests

The Director of Corporate Governance will maintain Registers of Declarations of Interests and Gifts, Hospitality, Honoraria and Sponsorship. Appropriate information from these Registers is available on the Health Board website.

The paper copy of the Register, together with the forms which are used to inform its contents will be retained by the Corporate Governance Team.

The Register is available for public inspection. Enquiries should be made to the Director of Corporate Governance via the following email: ABB.BoardSecretary@wales.nhs.uk

8. Declarations of Interest at Meetings

It is a requirement that at the beginning of every Health Board, Committee or decision making / formal Health Board meeting that members and those in attendance be invited to declare their interests in relation to any items on the agenda. Where a potential conflict is material or the member has a financial / pecuniary interest in the matter under discussion, that person shall withdraw from discussions pertaining to that agenda item and shall not vote upon it. The potential conflict and the action will be recorded in the minutes of the meeting and the Register of Interests will be updated if required.

Where it becomes evident part way through a meeting that there may be a potential conflict the individual must declare their interest immediately. Under certain circumstances the Chair may choose to waive the need for the individual to leave the meeting. The advice of the Director of Corporate Governance should always be sought prior to such a decision being made. From time to time, employees may need to declare interests at other Health Board or Partnership meetings. Such declarations will be recorded as if it were a Board or committee meeting and the individual will be asked to withdraw from discussions pertaining to that agenda item.

9. Gifts, Hospitality, Honoraria and Sponsorship

Employees and Independent Members have a personal responsibility to volunteer information regarding offers and acceptance of gifts, hospitality, honoraria and sponsorship, including those offers that have been declined. Employees should seek approval from their line manager prior to accepting any gifts, hospitality, honoraria or sponsorship. These details must be recorded on the Gifts, Hospitality, Honoraria and Sponsorship Form and submitted to the Director of Corporate Governance for inclusion on the register.

In determining whether to accept gifts, hospitality, honoraria and sponsorship, it is not always possible to make explicit a situation in which these may be considered acceptable as each offer should be considered independently. In determining whether any offer of a gift, hospitality,

honoraria or sponsorship should be accepted, the following principles should be considered:

- **Openness:** It has been openly offered and the offer will not be construed as any form of inducement and will not put the individual under any obligation to those offering it.
- **Legitimate interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the Health Board i.e. further the aims of the organisation.
- **Relationship:** Consideration should be given as to whether the Health Board is likely to enter into a contractual relationship with the organisation/ individual making the offer.
- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g. diaries/ calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation.
- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct.
- **Reputation:** If the body concerned is known to be under investigation by, or has been publicly criticised by, a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations. As such it should always be declined.

9.1.1 Gifts

A gift is an item of personal value, given by a third party e.g. a patient or a supplier. The definition includes prizes in draws and raffles at sponsored events / conferences.

It is a criminal offence under the Bribery Act 2010 to accept any money, gift or consideration as an inducement or reward from a person or organisation holding or seeking to hold a contract with the Health Board. Such gifts should be refused and if they have already been received they should be returned clearly advising why they cannot be accepted. The appropriate Director, Director of Corporate Governance and Head of Counter Fraud should be advised immediately.

Any acceptance of a gift needs to be justified. Think about the context in which the offer has been made, and the effect on your position. For example, is the gift likely, or could it be seen as likely, to influence you? The onus is on you to make sure that the acceptance of a gift will not be misconstrued.

9.1.2 Gifts from Patients/Service Users or their Relatives

Employees may accept, subject to it not contravening their professional Codes of Conduct, gifts up to the value of £25 from patients /service users and relatives as a mark of their appreciation for the care that has been provided. This can include items such as chocolates, flowers, cards. There is no requirement to declare such gifts.

Where a gift is offered by patients or their relatives that is likely to be over £25 in value it should be politely declined. In some cases the gift may have been delivered and it may be difficult to return it or it may be felt that the bearer may be offended by the refusal. Under such circumstances the gift can be accepted, and the bearer advised that it will be utilised for the benefit of the Charitable Funds e.g. used as a prize in a raffle. A Gifts, Hospitality, Sponsorship and Honoraria Form declaring that the gift has been received must be completed. Employees should seek approval from their line manager prior to accepting any gifts.

Personal gifts of cash or gift vouchers/cards from patients or their relatives are not acceptable. It may only be accepted as a donation to an appropriate Charitable Fund and recorded as such.

9.1.3 Gifts from Suppliers/Commercial Organisations

No gifts, unless they are of low intrinsic value e.g. diaries, calendars, etc. are allowable from suppliers, contractors and other commercial organisations. All such offers of gifts should be politely declined.

Whilst it is not necessary to declare gifts of low intrinsic value, where other items are offered and declined a Gifts, Hospitality, Sponsorship and Honoraria Form should be completed. This will allow the Health Board to monitor when such organisations are inappropriately offering gifts or potential inducements.

Under some circumstances suppliers may send gifts to all of its clients as custom and practice e.g. hampers at Christmas. Whilst such practices should be discouraged and it is not acceptable for staff to personally accept these gifts, following discussion with the supplier/commercial organisation and line manager it may be considered appropriate to accept the gift and utilise it for the benefit of Charitable Funds.

Gifts of cash (including gift vouchers/cards) from suppliers/commercial organisations are not acceptable in any circumstances.

9.1.4 Gifts from Dignitories / Overseas Organisations

There may be occasions when visits are made by dignitaries or overseas organisations who consider it "culturally custom and practice" to exchange gifts. In such cases Employees should seek guidance from their line manager initially and declare these gifts on a Gifts, Hospitality, Sponsorship and Honoraria Form. Further guidance may also be sought from the Director

of Corporate Governance. A decision will then be jointly made as to the most appropriate way to manage the gift. This will depend on the nature of the "gift culture" and may include decisions to keep and display in public, donate to an internal user group, auction for charity etc.

9.1.5 Gifts to Groups of Staff, Service/Department or Organisation-Wide

Non-monetary gifts are sometimes made to show appreciation to the NHS from a patient/service user and/or their relatives, the general public, community groups, local business, suppliers, contractors or commercial organisations. Staff may accept non-monetary gifts that are voluntarily donated by a third party to a group of staff (e.g. whole ward or department), a service/department, or the whole organisation rather than to an individual, where there is no expectation of the donor receiving anything in return and where there are no conditions attached to the gift. Employees should seek approval from their line manager prior to accepting any gifts.

Where these gifts represent tangible items such as IT equipment, medical devices or electrical items, consideration should be given prior to accepting the gift to matters such as their compatibility with health board systems, their on-going maintenance to comply with any warranties involved, storage, and any infection prevention issues with appropriate advice sought. Such gifts over the value of £25 should be declared on the Gifts, Hospitality, Honoraria and Sponsorship Form and registered to the group of staff or service/department receiving them. In addition, donated items over £5,000 must be recognised in the Health Board's Asset Register.

9.1.6 Bequests/Legacies/Wills

Employees are not permitted to accept bequests left to them by a deceased patient or service user who became known to them through providing care or treatment as part of their ABUHB employment. Accepting a gift of this nature, particularly where a patient is considered vulnerable, could leave the staff member open to accusations of financial abuse, fraud (by abuse of position) or misconduct. If an Employee is made aware that they may be a beneficiary in a patient's or service user's will e.g. by a deceased's legal representative, they must declare this to their line manager, with any complex cases escalated to the Director of Corporate Governance. In such a scenario, the Health Board will send a letter, endorsed by the employee, to those acting for the deceased's estate, advising that whilst the bequest cannot be accepted by the individual employee, the estate may, should they so wish, deposit the bequest in a designated charitable fund associated with the staff member involved, to benefit from a range of expenditure as per the charitable objectives of ABUHB's registered charity, Aneurin Bevan Health Charities, with the objective to "*provide those additional amenities that will improve the conditions under which patients are cared for and treated or staff work".*

9.2 Hospitality

Hospitality is where there is an offer of food, drink, accommodation, entertainment or entry into an event or function by a third party, regardless of whether provided during or outside normal working hours. Employees in contact with contractors should be particularly mindful of accepting any hospitality that might later be misconstrued as impacting on strict independence and impartiality.

Any acceptance of hospitality needs to be justified. Think about the context in which the offer has been made, and the effect on your position. For example, is the hospitality likely, or could it be seen as likely, to influence you? The onus is on you to make sure that the acceptance of hospitality will not be misconstrued.

9.2.1 Acceptable Hospitality

Acceptable hospitality includes:

Offers of food and non-alcoholic drink, provided it is equivalent to that offered in similar circumstances by the NHS, can be accepted during working visits and does not need to be recorded in the Gifts, Hospitality and Sponsorship Register.

Other hospitality that may be accepted includes instances where:

- There is a genuine need to impart information, or represent the Organisation at Stakeholder Community Events e.g. Local Authority or Charitable organisations which have an association with the Health Board.
- An employee has been invited to receive an award or prize in connection with the work of the organisation or their role within it.
- An employee is invited to a Society or Institute Dinner or Function which is to be funded by a commercial organisation and where there is a genuine benefit to the professional standing of the individual or the Health Board.

These types of hospitality must be authorised prior to their acceptance by their line manager and a Gifts, Hospitality, Sponsorship and Honoraria Form must be completed. The hospitality should be proportionate i.e. it should not be of significant value and only the minimum number of Employees to achieve the purpose of representing the Health Board should attend.

9.2.2 Unacceptable Hospitality

Unacceptable hospitality includes the following examples as general guidance:

- A holiday or weekend/overnight break.
- Offers of hotel accommodation when this is not associated with a sponsored course or conference (see below).
- Use of a company flat or hotel suite.
- Attendance at a function or event restricted to Employees which is not for the purposes of training or organisational development.
- Lunch or dinner provided by a private company or their representative which does not form part of a training or development event.
- Entertainment and/or tickets/hospitality at sporting and other corporate entertainment events.

If employees are not clear whether an offer falls into one of these categories advice should be sought from their line manager in the first instance or if complex from the Director of Corporate Governance.

Employees should report any case where an offer of hospitality is pressed which might be open to objection. They should also declare on the appropriate form any offers of hospitality which are declined.

9.3 Sponsorship

Sponsorship is sometimes provided by organisations to allow employees to attend conferences or working visits to view equipment. It may also include sponsorship of posts.

No sponsorship should be accepted without the prior agreement of the appropriate Line Manager. A Gifts, Hospitality, Sponsorship and Honoraria Form should also be completed prior to the acceptance of any sponsorship. If sponsorship is inappropriately offered and/or declined this should also be declared.

> Any acceptance of sponsorship needs to be justified. Think about the context in which the offer has been made, and the effect on your position. For example, is the sponsorship likely, or could it be seen as likely, to influence you? The onus is on you to make sure that the acceptance of any sponsorship will not be misconstrued.

More detail is provided below regarding the many forms that sponsorship may take.

9.3.1 Sponsorship for Research Projects

Sponsorship of a research project has specific legal responsibilities under the Clinical Trials Regulations. Before initiating a trial, the sponsor should define, establish and allocate all trial-related duties and functions. The NHS Research and Development (R&D) Forum *Sponsorship Principles* document provides a comprehensive summary of requirements, including various models of sponsorship and guidance on the allocation of responsibilities, duties or functions. If you wish the Health Board to Sponsor a research study you should contact the R&D Director prior to applying for a grant to ensure the Health Board is able to support the study or offer advice about alternative Sponsors.

9.3.2 Commercial Sponsorship for Attendance at Courses/ Conferences

Employees may accept commercial sponsorship for attendance at relevant conferences and courses, but only where the employee seeks permission in advance from their Line Manager. The sponsorship should only be extended to the number of Employees who would have normally attended if funded by the Health Board. The Line Manager must be satisfied that acceptance will not compromise purchasing decisions in any way.

9.3.3 Commercial Sponsorship to attend Demonstrations/Technical Evaluations

Employees may be invited to view products or equipment at another location. There may be occasions when it is appropriate as part of a procurement exercise to visit a suppliers' reference site to observe equipment in operation in a medical or laboratory setting. Such sponsorship is not usually considered appropriate and the Health Board will normally meet the costs of such a visit so as to protect the integrity of subsequent purchasing decisions.

Arrangements whereby the company meets all or part of the cost of such a visit must be approved by the appropriate Line Manager following consideration of the implications for the integrity of subsequent purchasing decisions.

9.3.4 Commercial Sponsorship for Sponsored Posts ('Linked Deals')

Pharmaceutical companies and other suppliers may offer to sponsor, wholly or partially, a post or equipment for ABUHB. The Health Board will not enter into such arrangements, unless it has been made clear to the company concerned that the sponsorship will have no effect on purchasing decisions within ABUHB.

Sponsored posts must be approved and managed in order that appropriate monitoring arrangements are established to ensure that purchasing decisions are not being influenced by the sponsorship agreement. Under no circumstances may 'linked deals' be agreed, whereby sponsorship is linked to the purchase of particular products, or to supplies from particular

sources.

Sponsored posts are posts that are funded, in whole or in part, by organisations external to the NHS. Sponsored posts can offer benefits to the delivery of care, providing expertise, extra capacity and capability that might not otherwise exist if funding was required to be used from the NHS budget. However, safeguards are required to ensure that the deployment of sponsored posts does not cause a conflict of interest between the aims of the sponsor and the aims of the organisation, particularly in relation to procurement and competition.

The following should be considered when sponsored posts are offered:

- External sponsorship of a post requires prior approval from the relevant Executive Director.
- Rolling sponsorship of posts should be avoided unless appropriate checks are put in place to review and withdraw if appropriate.
- Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements should conflicts of interest which cannot be managed arise.
- Sponsored post holders must not promote or favour the sponsor's products, and information about alternative products and suppliers should be provided.
- Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

The relevant Line Manager should declare any posts sponsored by external organisations on a Gifts, Hospitality, Sponsorship and Honoraria form and submit it to Director of Corporate Governance for recording on the register.

9.3.5 Sponsorship of Events in the Context of Partnership Arrangements with the Pharmaceutical Industry or other Commercial Organisations

The pharmaceutical industry and allied commercial sector representatives may organise meetings in support of specific functions or specialties within the healthcare sector. Under such arrangements they are permitted to fund the hiring of accommodation, meet any reasonable actual costs which may have been incurred and to provide appropriate hospitality. If no hospitality is required, there is no obligation or right to provide it, or indeed any benefit of equivalent value. An example of hospitality which would not be acceptable under these circumstances is where a company takes the attendees, on the conclusion of a course, for a meal in a restaurant.

The Pharmaceutical Industry is expected to adhere to the ABPI Code of Practice for the Pharmaceutical Industry which clearly specifies what is and what is not acceptable; this is available via the following link:
2021 Interactive ABPI Code of Practice - Comes into operation 1 July 2021 (pmcpa.org.uk)

9.3.6 Sponsorship for Events Hosted Wholly or Partly by ABUHB

Where the ABUHB receives or invites offers of sponsorship for events which are hosted wholly or partly by the Health Board, the relevant Line Manager must consider whether it is appropriate to accept the offer. For all offers, whether accepted or declined, a Gifts, Hospitality, Sponsorship and Honoraria form must be completed and sent to the Director of Corporate Governance for recording on the register.

The following guiding principles should apply:

- Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit for ABUHB and the NHS.
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.
- No information should be supplied to the sponsor from which they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.
- At the organisation's discretion, sponsors or their representatives may attend or take part in the event, but they should not have a dominant influence over the content or the main purpose of the event.
- The involvement of a sponsor in an event should always be clearly identified.
- Members of staff within the organisation involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.
- Members of staff arranging sponsored events must declare this to the organisation.

Whilst it is recognised that sponsorship can provide a useful source of funding for particular events or activities, it can also present risks and in considering whether to accept sponsorship, the following principles should be adhered to:

- Sponsorship should be sought in an open and even-handed manner with opportunities being offered as widely as possible.
- Benefits should be for the Health Board (not an individual) and should be proportionate.
- Arrangements must not compromise the standing or image of ABUHB i.e. they must be ethical.
- Sponsorship should be for a specific activity or event and not a general endorsement of the Health Board.

- The sponsorship must not imply that ABUHB endorses particular products, services or companies and organisations.
- Sponsorship should not be accepted from inappropriate sources, such as companies with dubious or doubtful backgrounds or who have poor financial or business practices.
- Arrangements must not bring adverse publicity to the event or the Health Board.

Particular care should be taken when considering sponsorship from companies or organisations for which the Health Board has, or could have, contractual business arrangements. The above principles should be adhered to and a renewal or an award of a contract should not be influenced by any sponsorship arrangements.

A sponsor would normally expect to receive a reciprocal benefit which may be beyond a modest acknowledgement, and companies may seek sponsorship for a number of legitimate business reasons. These include:

- To raise the company's image and profile.
- To improve public/ community relations.
- To generate public exposure and media coverage.
- To differentiate the company from its competitors.
- To increase profit/ market share.

Careful consideration should always be given to understanding what a sponsor might gain from the arrangement and these should be in keeping with the principles listed above.

Employees and Independent Members may, on occasion, be asked to provide an endorsement of an event, conference or training course that they have attended which was organised by a third party.

Caution should be exercised in these circumstances as it may not be appropriate to cite such an endorsement. It is also important to consider any potential future conflict, for example, where the third party may be in the process of re-tendering for the work or be seeking commercial gain from the endorsement.

ABUHB may also receive unsolicited proposals for sponsorship which is not in response to any action that the Health Board has taken. The Health Board should carefully consider such offers and ensure that the proposal meets the Health Board's requirements, standards and principles. ABUHB will need to ensure there are no conflicts of interest or that better value for money cannot be obtained by testing wider market interest.

All sponsorship arrangements should be approved by the appropriate Line Manager.

9.4 Honoraria and Miscellaneous Payments

An honorarium is an *ex gratia* payment i.e. one which would not usually be expected to be provided.

Employees may be invited to give presentations at conferences, provide responses to surveys or attend professional meetings where a one-off payment or honorarium is offered. If this activity is to be undertaken during hours when the Employee is contracted to work for ABUHB, the payment should be made to ABUHB. Individuals may accept payment for activities that they undertake in their own time, subject to the provisions regarding outside employment contained within the various Employee Contracts and Terms of Service. The activity should be reported using a Gifts, Hospitality, Honoraria and Sponsorship Form.

N.B There are tax and national insurance contribution implications relating to honoraria that should be borne in mind as set out below:

Honoraria received for work undertaken during Health Board hours:
When appropriate authorisation has been granted to permit an employee to be involved in activity outside their normal contract during Health Board hours, any honoraria paid must be received back to the Health Board revenue budget to reimburse the Health Board for the Employee's time.

To ensure good governance, the honoraria must be paid into a revenue budget that is **not** managed by the Employee who has provided their services during Health Board time.

To avoid personal tax implications, the Employee is strongly advised to request the honoraria is paid directly to the Health Board. This is then seen as reimbursement to the Health Board to cover the loss of Employee time, and not honoraria. This money will then be transferred into the Health Board's revenue budget. The Employee who has undertaken the work must **not** be the budget holder for the budget receiving the funds in lieu of the honorarium to avoid any conflict of interest.

Where the Employee receives the honoraria directly and then reimburses the Health Board, the Employee remains liable for the payment of both tax and National Insurance Contributions (NIC), regardless of the final destination of the honoraria.

Honoraria received for work undertaken in an individual's own time (out of normal working hours or on authorised annual leave): Individuals are personally liable for the payment of both tax and NICs on any honoraria payments received for work undertaken in their own time.

Where an Employee wishes, a donation may be made to Aneurin Bevan University Health Board Charitable Funds in lieu of an honoraria. This must be received into the Charity's general fund and it is then for the Charity Trustees to determine how the donated funds should be used. The basic principle being that the employee giving their own time should have no influence over how the donation is then used and therefore lessens the risk of this being interpreted as being of any benefit to them as 'income' in any sense.

In cases of doubt, staff should seek advice from the Director of Corporate Governance and should report any case where an offer of sponsorship or honoraria is pressed which might be open to objection. Instances where honoraria has been offered and declined should still be declared on the Gifts, Hospitality, Honoraria and Sponsorship Declaration Form.

9.4.1 Gifts by Way of Inducement or Reward

The Bribery Act 2010 prohibits staff from soliciting or receiving any gift or consideration of any kind from contractors or their agents, or from any organisations, firms or individuals with whom they are brought into contact by reason of their official duties, as an inducement or reward for:

a) Doing or refraining from doing anything in their official capacity; or
b) Showing favour or disfavour to any person in their official capacity.

It should be understood that a breach of the provisions of this Acts renders staff liable not only to dismissal but to prosecution under the Act, and it is expected that the Health Board would deal severely with any such breaches. Any instances would be referred to Counter Fraud for investigation, with a view to prosecution by the Crown Prosecution Service.

Staff should be aware that the Health Board is required in accordance with its Standing Orders to insert in every formal contract a clause entitling them to cancel the contract and recover any losses if any inducement or gifts are offered by the contractor or by his employees, whether with or without his knowledge. Any such offer of an inducement or gift should accordingly be reported by the person to whom it is made to the Director of Corporate Governance.

10. Secondary Employment and Private Practice

Secondary Employment (Paid, Unpaid or Self-Employed)

Employees should inform their line manager of any secondary employment and ensure that this does not affect their ABUHB employment. Declarations should be made using the Staff Declaration of Interests Form. There should be no conflict with their normal contractual employment obligations to ABUHB, and such work should not involve the use of any confidential or commercial information obtained in the course of their employment with ABUHB.

Where Employees have or are contemplating other employment, they must ensure this does not compromise their availability or physical or mental fitness to perform their duties as an Employee of ABUHB. Employees must also ensure this does not place them in a position where their judgement or actions might be influenced by considerations arising from their other employment.

Employees have a responsibility to ensure that their line manager is made aware of any hours worked in order that the Health Board fulfils its statutory requirement of the Working Time Directive.

An Employee, absent because of sickness, is regarded as unfit to work and should not undertake any paid or unpaid work in any capacity during a period of sickness absence from the organisation, unless it is deemed jointly by their manager and the Occupational Health Department to be therapeutically beneficial to their recovery. Express written permission must be granted by the manager in advance in all such cases.

An employee found to be undertaking other work during sickness absence without the prior written consent of the manager, may be considered in breach of contract and will be subject to disciplinary action, which may result in the involvement of the Counter Fraud Department, the possibility of criminal investigation and/or dismissal.

Private Practice

There are codes for good private patient practice which clearly include the fact that private practice should not adversely affect NHS duties.

The Health Board has a Private Practice Policy which provides medical staff with appropriate governance in understanding their contractual obligations and organisational expectations in relation to the undertaking of private practice.

Whilst the Policy is primarily directed at Consultants undertaking private patient activity, it equally applies to any other medical staff employed by the Health Board who may privately charge for their services whilst using NHS facilities, equipment or staff, or who may undertake such activities during NHS time, including private patients travelling from outside of the UK.Link to policy once approved

11. Research and Development

Before undertaking any research, the Health Board Research and Development Department must be contacted to ensure the appropriate approvals are in place. Research should always be fully costed and supported by either a Commercial or Non-Commercial Grant. This includes post marketing product evaluations. Research is governed by a number of frameworks and regulations including:

- The UK Policy Framework for Health and Social Care (UK Policy Framework)
- Medicines for Human Use (Clinical Trials) Regulations 2004 (as amended)

Anyone wishing to undertake or be part of research project will be required to hold a current ICH GCP certificate, registered with the Research and Development Department.

The Research and Development Department should always be contacted in these circumstances to offer advice and support in this area.

12. Rewards for Initiative

Potential intellectual property rights (IPR) should be identified, as and when they arise, in order to protect and ensure that the ABUHB receives any rewards or benefits (such as royalties) in respect of work commissioned from third parties, or work carried out by its Employees in the course of their duties.

Most intellectual property is protected by statute e.g. patents are protected under the Patents Act 1977, and copyright (which includes software programmes) under the Copyright Designs and Patents Act 1988. Appropriate specifications and provisions should be built into contractual arrangements before they are entered into or before work is commissioned or begins. Legal advice or advice provided via the Research & Development Department should be sought if in doubt in any specific cases.

With regard to patents and inventions, in certain defined circumstances the Patents Act 1977 gives Employees a right to obtain reward for their efforts, and the Health Board should agree a suitable reward for individual circumstances as appropriate. Other rewards may be given voluntarily to Employees who within the course of their employment have produced innovative work of outstanding benefit to the NHS. Similar rewards should be voluntarily applied to other activities such as giving lectures and publishing books and articles.

In the case of collaborative research and evaluative exercises with manufacturers, the Health Board should obtain a fair reward for the input its Employees provide. If such an exercise involves additional work for an Employee outside that paid for by the Health Board under their contract of employment, arrangements should be made for a share of any rewards or benefits to be passed on to the Employee(s) concerned from the collaborating parties.

Care should be taken that involvement in this type of arrangement with a manufacturer does not influence the purchase of other supplies from them.

Employees are reminded that all information generated during the course of their employment with ABUHB is the property of the Health Board and remains so, irrespective of origin or authorship.

Conflicts of interest can arise when a member of staff who hold patents and other intellectual property rights is involved in decision making and procurement. In addition, where product development involves use of time, equipment or resources from the organisation, this can also create risks of conflicts of interest, and it is important that the Health Board is aware of this in order to manage it appropriately.

Employees are responsible for:

- Declaring patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might reasonably be expected to be, related to items to be procured or used by the organisation.
- Seeking prior permission from ABUHB before entering into any agreement with bodies regarding product development, research, work on pathways, etc, where this impacts on the organisation's own time, or uses its equipment, resources or intellectual property.
- Where holding of patents and other intellectual property rights give rise to a conflict of interest, then the management actions outlined in this policy should be considered and applied to mitigate risks.
- Members of staff are also reminded of their responsibilities to ensure the correct use of copyrighted information.

13. Charitable Funds

There may be occasions when commercial organisations offer to make a donation into the ABUHB Charitable Funds. Monies paid into charitable funds from commercial companies must only be accepted as donations. Any offers where there is a benefit in return should be considered under the policy section relating to *Sponsorship for Events Hosted Wholly or Partly by ABUHB* (p.XX). Where donations are received, they should only be used to fund expenditure which is in line with the terms of the charitable fund's use

Expenditure from Charitable Funds and charitable fundraising within the workplace does not fall within the remit of this policy, however there may be a close association. Further guidance is available from the Charitable Funds Manager.

14. Failure to Adhere to Standards of Behaviour Policy

If any Employee or Independent Member fails to declare an interest or gift, hospitality, honoraria or sponsorship as defined within this policy or the Standards of Behaviour Framework, and then:

- participates in a decision-making process where special favour is shown to unfairly award a contract; or
- abuses their official position or knowledge for the purpose of benefit to themselves, their family or friends

disciplinary action may follow. The action taken will depend on the individual circumstances and will be in accordance with the Health Board's Disciplinary Policy. Under some circumstances, failure to follow this policy could be considered gross misconduct.

In addition to any potential disciplinary action being taken, if there is any suspicion that fraud, corruption and/ or bribery has been or is being committed, then all such cases must be reported at the earliest possible opportunity to the Local Counter Fraud Specialist (LCFS) within ABUHB. This is also extended to include the inappropriate acceptance of any gifts, hospitality, honoraria or sponsorship.

Furthermore, if an employee breaches the Standards of Behaviour Policy or Framework, this could in certain circumstances result in notification/ reporting to the appropriate professional codes of conducts/ registration/ memberships i.e. Health Professions Council (HPC), General Medical Council (GMC), Nursing and Midwifery Council (NMC), etc. This could incur registrations being revoked and Employees no longer continuing to be employed in their current position within the Health Board.

Failure to declare a relevant interest by an Independent Member of the Board will be reported by the Chair to the Minister for Health and Social Services.

15. Consultation

The following groups were consulted with during the development of this policy:
Workforce and OD Policy Group
Audit, Risk and Assurance Committee
EQIA Group

16. Equality Impact Assessment

TO be completed following EQIA

17. Training Requirements

There are no training implications arising from this Policy and the Standards of Behaviour Framework. However, awareness sessions will be held with

managers. The importance of continued compliance will require reference in induction programmes, during Individual Performance Reviews, Consultant Appraisals, Consultant Job Plan Reviews and at times when Employees are invited to make declarations.

18. Audit and Review

The Director of Corporate Governance is responsible for the monitoring of this policy and its formal review every three years.

The Director of Corporate Governance will arrange for the Declarations of Interest Register and an overview of the gifts, hospitality, honoraria and sponsorship activities within ABUHB to be presented to the Audit, Risk and Assurance Committee at the end of each financial year.

The Audit, Risk and Assurance Committee will review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests, gifts, hospitality, honoraria and sponsorship at least annually.

Audit Wales and the Health Board's Internal Audit Service may also review the arrangements from time to time and their findings are also reported to the Audit, Risk and Assurance Committee.

Staff should note that following implementation of the Freedom of Information Act 2000 the information contained within the Health Board Register will be subject to disclosure to any member of the public on request.

19. Legislative and NHS Requirements

This policy aims to ensure that the Health Board complies with the requirements set out in: -

a) (DGM(93)84) Standards of Business Conduct for NHS Staff
b) WHC(2005)016 – The NHS and Sponsorship by the Pharmaceutical Industry
c) WHC(2006)090 - The Codes of Conduct and Accountability for NHS Boards and the Code of Conduct for NHS Managers Directions 2006
d) Director General, Health and Social Services, Chief Executive NHS Wales, Shared Values and Reinforcing Behaviour in NHS Wales (January 2011)
e) Commercial Sponsorship - Ethical Standards for the NHS, Department of Health (November 2000)
f) Code of Practice for NHS Wales Employers, Welsh Assembly Government (January 2011)
g) Code of Conduct for Healthcare Support Workers in Wales, Welsh Assembly Government (January 2011)
h) General Medical Council – Conflicts of Interest (September 2008)
i) Health Board Standing Orders, Reservation and Delegation of Powers
j) Nursing and Midwifery Council, The code - Standards of conduct,

performance and ethics of nurses and midwives (May 2008)

k) Royal College of Psychiatrists, Good Psychiatric Practice, Relationships with Pharmaceutical and Other CommercialOrganisations (2008)

l) Association of the Pharmaceutical Industry (ABPI), Code ofPractice for the Pharmaceutical Industry (November 2011)

m) The Institute of Chartered Secretaries and Administrators (ICSA), Model Conflicts of Interest Policy for NHS Trust Board Members (June 2010)

n) The Bribery Act 2010

o) NHS Counter Fraud Authority.

p) Health Board Policy on Intellectual Property

20. Acknowledgements

This policy has been reviewed and developed against the following Health Board policies:

- Hywel Dda University Health Board Standards of Behaviour Policy (October 2022)
- Cwm Taf Morgannwg University Health Board Standards of Behaviour Policy (January 2023)
- Cardiff and Vale University Health Board Standards of Behaviour Policy (November 2022)

21. Appendices

Appendix One – Standards of Behaviour Framework

Appendix Two – Declarations of Interest Form

Appendix Three – Hospitality, Honoraria and Sponsorship Form

Appendix Four – Declaration Statement Honoraria

Aneurin Bevan University Health Board Standards of Behaviour Framework

"Public service values and associated behaviours are and must be at the heart of the NHS in Wales"

The Board has described those values that underpin the way that services are provided within ABUHB. To support this, all employees must ensure that they carry out their roles with dedication and commitment to the Health Board and its core values.

All staff must have the highest standards of corporate and personal conduct and behave in an exemplary manner based on the following seven principles:

Selflessness – Individuals should act solely in terms of the public interest. They should not do so in order to gain financial orother benefits for themselves, their family or friends;
Integrity – Individuals should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in theperformance of their official duties;
Objectivity – In carrying out public business, including making public appointments, awarding contracts, recommending individuals for rewards and benefits, choices should be made on merit;
Accountability – Individuals are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate for their position;
Openness – Individuals should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands it;
Honesty – Individuals have a duty to declare any private interests relating to their duties and to take steps to resolve any conflicts arising in a way that protects the public interest, and;
Leadership – Individuals should promote and support these principles by leadership and example.

To ensure these principles you must:

- Ensure that the interests of patients remain paramount;
- Be impartial and honest in the conduct of your official business;
- Use NHS resources to the best advantage of the service and the patients, always seeking to ensure value for money;
- Not abuse your official position for personal gain or to benefit family or friends;
- Not seek advantage or to further private business or other interests in the course of your official duties; and
- Not seek or knowingly accept, preferential rates or benefits in kind for private transactions carried out with companies, with which they have had, or may have, official dealings on behalf of the Health Board.

The Standards of Behaviour Policy outlines the arrangements in Aneurin Bevan University Health Board to ensure that staff comply with these requirements including recording and declaring potential conflicts of interest and handling of gifts, hospitality, honoraria and sponsorship (even if these are declined).

It is **your responsibility** to ensure that you are familiar with the requirements of the policy and supporting guidance. The relevance of this information will vary depending on your role within the Health Board and your interests outside of your employment.

DO:

Declare any relevant interests. These include:-
- Directorships, including Non-Executive Directorships held in private companies or PLCs.;
- Ownership or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the Health Board.
- A position of authority in a charity or voluntary body in the field of health and social care;
- A personal or departmental interest in any part of the pharmaceutical or healthcare associated industries that could be perceived as an influence on decision making or on the provision of advice to members of the team;
- Sponsorship or funding from a known NHS supplier or associated company/subsidiary;
- Employment where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice;
- Anything else that could cause a potential for conflict.
- Remember that the need to declare an interest also includes those of your close family and possibly friends.
- Seek your manager's permission before taking any outside work, in accordance with employment terms and conditions.
- Obtain your Directors permission before accepting any commercial sponsorship or hospitality;
- Declare offers of gifts, hospitality or sponsorship using the appropriate form where required.

If in doubt declare it!

DO NOT:

- Accept any gifts from suppliers or commercial organisations unless they are of low value e.g. pens, diaries;
- Accept any gifts over the value of £25 from patients or their relatives, these should bepolitely declined;
- Accept personal gifts of cash ot gift vouchers/cards of any value.
- Accept any inappropriate hospitality or sponsorship from suppliers or commercial organisations;
- Abuse your position to obtain preferential rates for private deals;
- Unfairly advantage one competitor over another or show favouritism in your dealings with commercial organisations;

DECLARATION OF INTERESTS FORM
FOR BOARD MEMBERS AND EMPLOYEES

Full Name: (Please Print)	
Division:	
Contact email/phone:	
Position Held in Health Board:	

In accordance with the following:

- **Code of Conduct and Accountability,**
- **Health Boards Standards of Behaviour Framework Policy.**
- **Standing Orders and Standing Financial Instructions**

and

- **'International Accounting Standard (IAS) 24- Related Party Disclosures.**

I list below my relevant interests and those of my close family/friends for inclusion in the Register of Interests.

In accordance with the terms of IAS 24 referred to above please consider the following when considering interests that may need to be declared:

- **any pecuniary interests** e.g. company shares, any employment or trade carried out for profit or gain
- **any control or joint control / authority over a reporting entity;**
- **any significant influence / authority over a reporting entity;**

or

- **any membership of key management**
-

If in doubt, declare!

Proceed to Section f) if you have 'Nil Interests' to declare.

Declaration	Nature of Relationship	Period of Involvement	Financial Transactions or Benefits in Kind
a) DIRECTORSHIPS Public or private appointments, employment or consultancies. Company (including Non-Executive Director) directorship's in private or limited companies (with the exception of dormant companies)	Personal:		
	Spouse/Partner or other relationship specific to a contract:		
b) INTEREST IN COMPANIES AND SECURITIES Substantial interest in, ownership or part ownership, more than 1/100th (i.e. share) of private companies, businesses or consultancies likely or possibly seeking to do business with ABUHB	Personal:		
	Spouse/Partner or other relationship specific to a contract:		
c) OTHER POSITIONS OF AUTHORITY (not included in "Directorships" A position of authority (i.e. Director, Chairman. Trustee etc.) in a charity or voluntary body in the field of health and social care	Personal:		
	Spouse/Partner or other relationship specific to a contract:		

d) PERSONAL OR DEPARTMENTAL SPONSORSHIP A personal or departmental interest in any part of the pharmaceutical/healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team.	Personal:		
	Spouse/Partner or other relationship specific to a contract:		
e) Sponsorship or funding from a known NHS supplier or associated company/subsidiary			
f) A position of authority in a charity or voluntary body in the field of health and social care			
g) Any other connection with a voluntary, statutory, charitable or private body that could create a potential conflict of interests			
h) ANY OTHER EMPLOYMENT/SELF EMPLOYMENT by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice	Personal:		
	Spouse/Partner or other relationship specific to a contract:		

DECLARATION:

I understand:

- **That the information submitted will be held by the Health Board for personnel or other reasons specified below to comply with the Health Board Policies and Procedures.**
- **This information may be held in both manual and electronic form in accordance with relevant legislation.**
- **Information may be disclosed to third parties in accordance with the Freedom of Information Act, and published in registers that the Health Board holds and makes available in the public domain.**
- **This information will be available in its entirety for public inspection.**
- **That copies of my declaration form will be shared with relevant functions to support year-end reporting e.g. Finance and Procurement.**
- **I understand that declarations will be published unless there are exceptional circumstances as to why they should not be – please see box below.**

I consent to the disclosure of relevant information on this form for the purposes of fraud prevention, detection

and investigation.

I undertake to notify the Health Board of any changes, which may occur within four weeks from the date of the

change.

I declare that the information given on this form is true and complete to the best of my knowledge. I understand that action may be taken against me if I make a false statement.

i) I confirm a NIL declaration	
Signed:	**Date:**

j) I confirm that the list accurately reflects my interests and those of my close family and understand that these declarations will be included in the register available *public inspection*	
Signed:	**Date:**

By ticking this box I understand that I am indicating that I consider that there are exceptional circumstances as to why my declaration should not be published. ☐ **PLEASE NOTE: if you have ticked the above box, the Corporate Governance Team will make contact toestablish if you have reasonable grounds for your declaration to be excluded on registers that the Health Board holds and publishes.**

COMPLETION BY LINE MANAGER				
k) Authorisation Section				
Having considered the activity declared on this form is there any action required to manage any potential conflicts of Interest? Please indicate with a (X) in the relevant box.	**Yes** ***If yes, please outline in the 'Management Action' box below the steps and action that will be taken to manage any potential conflict***		**No**	
If a conflict has been identified have you sought advice from the Director of Corporate Governance for advice on how to manage and report the conflict? Please indicate with a (X) in the relevant box.	**Yes**		**Not Applicable**	
Management Action Agreed: ***(if not applicable please indicate this by writing N/A in the box below)***				
By signing below you are confirming that you have: • **Considered the activity Declared on this form.** • **Identified if there are any potential conflict of interest** • **If a declaration of interest is perceived, considered the management action required to manage the conflict, sought advice from the Director of Corporate Governance and;** • **Communicated the action required to the individual declaring the interest**				

Print Name:	
Designation:	
Signature:	

Date:	

Please submit completed forms to:
By Post: Rani Dash, Director of Corporate Governance, Headquarters, St. Cadocs Hospital, Lodge Road, Caerleon, NP18 3XQ
By email: abb.boardsecretary@wales.nhs.uk

Hospitality, Honoraria and Sponsorship Form

It is a requirement that staff advise ABUHB if they accept or are offered any gifts, hospitality or sponsorship in accordance with the Health Board's Standards of Behaviour Framework Incorporating Declarations of Interest Gifts, Hospitality & Sponsorship Policy.Once approved by the Line Manage (with budget management responsibilities) the form should be forwarded to the Director of Corporate Governance for inclusion in the Register of Gifts, Hospitality and Sponsorship.

Please Note: This form should be used to seek the approval to accept any gifts, hospitality or sponsorship **PRIOR to acceptance.**

Please Note: Tax Implications of Honoraria:

i) *Honoraria received for work undertaken during ABUHB hours*

When appropriate authorisation has been granted to permit an employee to be involved in activity outside their normal contract during ABUHB hours, any honoraria paid must be received back to the ABUHB revenue budget to reimburse ABUHB for the employee's time.

To ensure good governance, the honoraria must be paid into a revenue budget that is not managed by the employee who has provided their services during ABUHB time.

To avoid personal tax implications, the ABUHB employee is urged to request the Honoraria is paid directly to ABUHB. This is then seen as reimbursement to ABUHB to cover the loss of employee time, and not honoraria. This money will then be transferred into the ABUHB revenue budget. The ABUHB employee who has undertaken the work must not be the budget holder for the budget receiving the funds in lieu of thehonorarium due to a conflict of interest.

If the employee receives the honoraria directly and then reimburses the ABUHB, the employee ***remains liable for the payment of both tax and NIC****, regardless of the final destination of the honoraria.*

ii) *Honoraria received for work undertaken in an individual's own time (out of normal working hours or on authorised annual leave)*

Individuals are ***personally liable for the payment of both tax and NICs*** *on any honoraria payments received.*

If such an employee wishes to suggest a donation may be made to the ABUHB Charity in lieu of an honoraria, this must be received into the Charity's general fund and it is then for the Charity Trustees to determine how the donated funds should be used. The basic principle being that the employee giving their own time should have no influence over how the donation is then used and therefore lessens the risk of this being interpreted as being of any benefit to them as 'income' in any sense.

Full Name:	Position:	Department:
Gift: ☐ Hospitality: ☐ Sponsorship: ☐ Honorarium ☐		Accepted: ☐ Declined: ☐
Event Details including location (if applicable):		
Start Date of Event: (If Applicable)		End Date of Event: (If Applicable)
Description: (Including course title, fees, travel, accommodation etc.)		
Sponsor/Donor: (Name & address of organisation/company/individual)		
Are you aware of any current or future commercial relationship with the provider of the gift/ hospitality/ sponsorship/ honorarium?		

Exact/Approximate Value:	
Travel	£
Accommodation	£
Meals/Refreshments	£
Conference/Registration Fees	£
Other (please specify)	£

Study Leave Required?	Has a Study Form Been Completed?
Yes ☐ No ☐	Yes ☐ No ☐
Annual Leave Required?	
Yes ☐ No ☐	

DECLARATION:

I understand:

- **That the information submitted will be held by the Health Board for personnel or other reasons specified below to comply with the Health Board Policies and Procedures.**
- **This information may be held in both manual and electronic form in accordance with relevant legislation.**
- **Information may be disclosed to third parties in accordance with the Freedom of Information Act, and published in registers that the Health Board holds and makes available in the public domain.**
- **This information will be available in its entirety for public inspection.**
- **That copies of my declaration form will be shared with relevant functions to support year-end reporting e.g. Finance and Procurement.**
- **I understand that declarations will be published unless there are exceptional circumstances as to why they should not be – please see box below.**

I consent to the disclosure of relevant information on this form for the purposes of fraud prevention, detection and investigation.

I declare that the information given on this form is true and complete to the best of my knowledge. I understand that action may be taken against me if I make a false statement.

By ticking this box I understand that I am indicating that I consider that there are exceptional circumstanced as to why my declaration should not be published. ☐ **PLEASE NOTE: if you have ticked the above box, the Corporate Governance Team will make contact to establish if you have reasonable grounds for your declaration to be excluded on registers that the Health Board holds and publishes.**

Signature of Applicant: ……	Date:
Approved by (Director/Executive Director): Print Name : Signature: ……	Date:

Please return the fully completed approved declaration to:ABB.boardsecretary@wales.nhs.uk

For Corporate Governance Team Completion Only	
Recorded on Register of Gifts, Hospitality & Sponsorship: Print Name : Signature: ……..	Date:

DECLARATION STATEMENT

TAX AND NATIONAL INSURANCE CONTRIBUTIONS INRESPECT OF HONORARIA

I confirm that I am aware of the Personal Tax and National Insurance contributions responsibilities associated with receiving honoraria payments, as outlined in the Health Board's Standards of Behaviour Policy.

I understand that where honoraria is received for events undertaken in my own time (out of normal working hours or on authorised leave) I am **personally liable** for the payment of both Tax and National Insurance contributions on any honoraria payments received and it is my responsibility to personally declare this income to the inland revenue.

Where an honorarium is received for events undertaken in work time/and or whilst on study leave I will advise the sponsor that the payments should be paid direct to the Health Board. These funds will then be reimbursed to the appropriate Health Board revenue budget.

Print Name:	
Position:	
Signature:	
Date:	

Corporate Governance

Received by:	
Position:	
Signature:	
Date added to Register	

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	21 May 2024
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Draft Annual Report 2023/24
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Bryony Codd, Head of Corporate Governance

Pwrpas yr Adroddiad Purpose of the Report
Ar Gyfer Trafodaeth/For Discussion

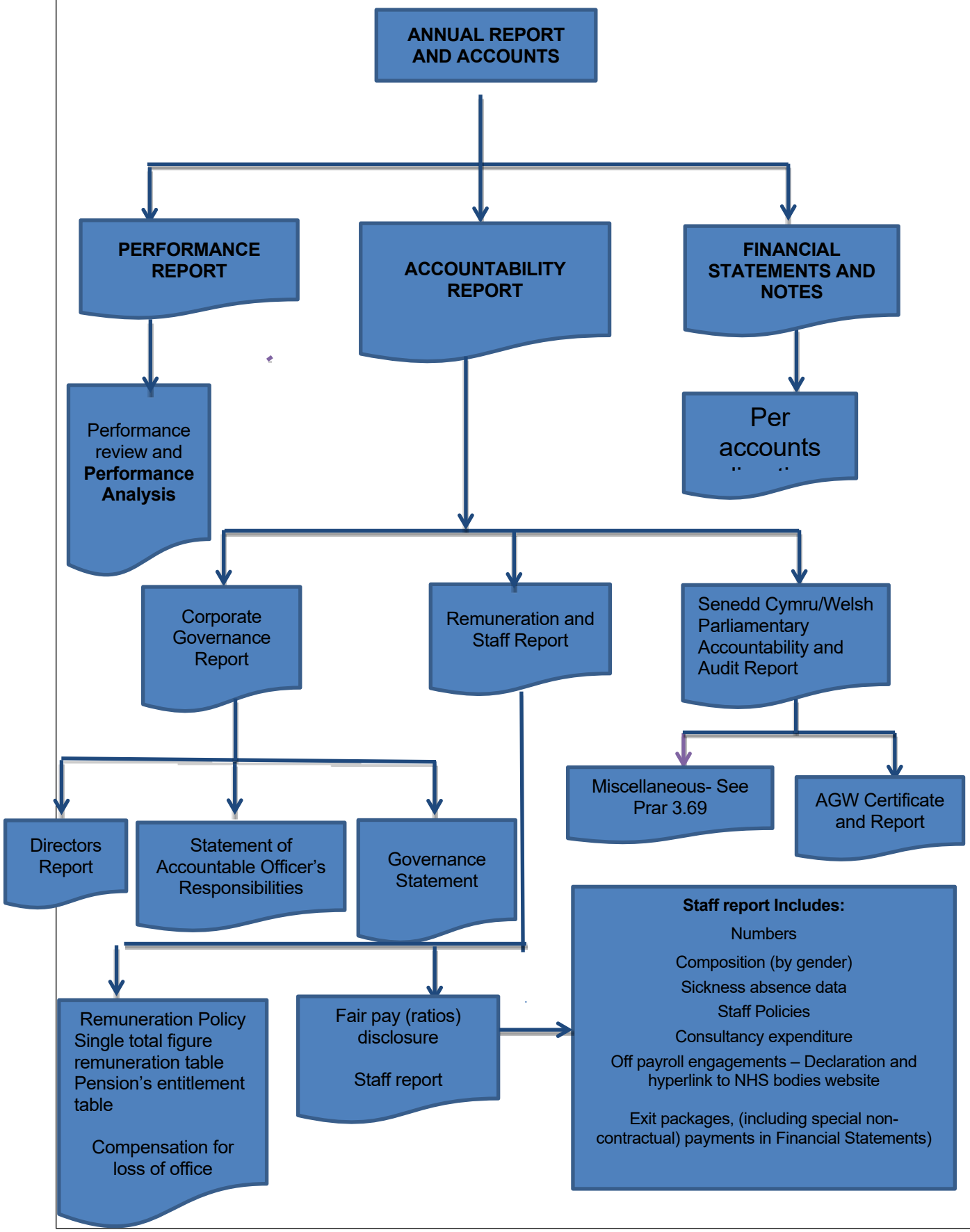
ADRODDIAD SCAA SBAR REPORT
Sefyllfa / Situation This paper presents to the Audit, Risk and Assurance Committee the first draft Performance and Accountability Reports 2023/24. In line with Chapter 3 of the Manual for Accounts: Annual Report and Accounts, the Health Board is required to publish, as a single document, a three part Annual Report and Accounts. Parts 1 and 2, the Performance Report and Accountability Report are provided for consideration by the Audit, Risk and Assurance Committee. The draft Accounts have been provided as a separate document.

Cefndir / Background
 	
This paper presents to the Audit, Risk and Assurance Committee the first draft Performance Report and Accountability Report 2023/24. In line with Chapter 3: Annual Report and Accounts, the Health Board is required to publish, as a single document, a three part Annual Report and Accounts which includes:
 	
• The Performance Report, which must include:
  ○ An overview.
  ○ Performance analysis
 	
• The Accountability Report, which must include:
  ○ A Corporate Governance Report.
  ○ A Remuneration and Staff Report.

- Senedd Cymru/Welsh Parliament Accountability and Audit Report.

- The Financial Statements, including:
  - The Audited Annual Accounts 2023-24

Outline Structure



Asesiad / Assessment

This report presents the first drafts of the Performance Report and Accountability Report.

The timetable for submission is outlined below:

Annual Reports 2023/24 - Key Dates	**2024**	
Draft Performance Report Overview, Accountability Report and Remuneration Report to WG	**Fri**	**10-May**
Draft Reports to ARA Committee Members	Tue	14 -May
ARA Committee meeting to Consider Draft Accounts and Draft Accountability Report	Tue	**21-May**
Final Accounts & Accountability Report to Audit Committee Members	Wed	3-July
ARA Committee meeting to Consider Final Accounts, and Accountability Report	Tues	**9-July**
Board meeting to approve Final Accounts and Accountability Report	Thurs	**11-July**
Certification by Auditor General	Mon	**15-July**
Final Annual Report Deadline for Submission to WG – Annual Report and Accounts as a single unified document	Mon	**15-July**
Annual General Meeting – to receive the Annual Report and Accounts	Wed	25-Sept

In line with the required timescales, the first draft report was submitted to Welsh Government and Audit Wales by 10th May 2024. These documents continue to be working documents, based on template guidance and are subject to ongoing refinement.

Members of the Audit, Risk and Assurance Committee are asked to consider the attached documents and provide comments for inclusion in the final draft of the report for consideration at their meeting on 9th July 2024.

The final Chapter 3 of the Manual for Accounts confirms the requirement for a public meeting to be held no later than 30 September 2024, at which the Annual Report and audited accounts are presented. This therefore supersedes the requirement in the Health Board's Standing Orders to hold the Annual General Meeting by the end of July.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to consider and comment on the draft Performance Report and Accountability Report prior to preparation of the final reports for submission to the Committee on 9th July 2024.

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

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
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)	
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

Aneurin Bevan University Health Board Annual Report and Annual Accounts 2023/24

Our Annual Report is a suite of documents that tell you about our organisation, the services and care we provide and what we do to plan, deliver and improve healthcare for you. It provides information about how we performed in 2023/24, what we have achieved, how we plan to continue to improve next year and our plans for the future. This report also explains how important it is for us to work with you and listen to your views, to better deliver services that meet your needs, as close to your home as possible.

Our Annual Report for the period 1st April 2023 to 31st March 2024 includes:

- Our **Performance Report** which details how we have performed against our targets and the actions planned to maintain or improve our performance.

- Our **Accountability Report** which details our key accountability requirements and provides information about how we manage and control our resources, identify and respond to our risks, and comply with our own governance arrangements.

- Our **Financial Statements and Annual Accounts** which detail how we have spent our money and met our obligations.

Contact Us

You can contact the Health Board using the details below:

Aneurin Bevan University Health Board
Headquarters, St Cadoc's Hospital
Lodge Road, Caerleon, Newport, NP18 3WQ
Telephone; 01633 436700 or email abhb.enquiries@wales.nhs.uk
http://twitter.com/aneurinbevanhb
https://www.facebook.com/AneurinBevanHealthBoard

Section One – The Performance Report	
1. Overview from the Chief Executive 2. Reporting Requirements 3. Aneurin Bevan University Health Board 4. Integrated Medium Term Plan 2023/24 – Life Course 5. Delivering the IMTP Priorities 2023/24 6. Integrated Medium Term Plan 2023/24– Priority Programmes 7. Integrated Medium Term Plan 2023/24 – Quality and Safety 8. Well Being of Future Generations 9. Equality, Diversity and Inclusion 10. Welsh Language Requirements 11. Financial Management and Performance 12. Conclusion and Forward Look	
Section Two – The Accountability Report	
Corporate Governance Report • Directors Report • Statement of Accountable Officer's Responsibilities • Annual Governance Statement	
Remuneration and Staff Report	
Parliamentary Accountability and Audit Report	
Section Three – The Financial Statements	
The Audited Annual Accounts 2023-24	

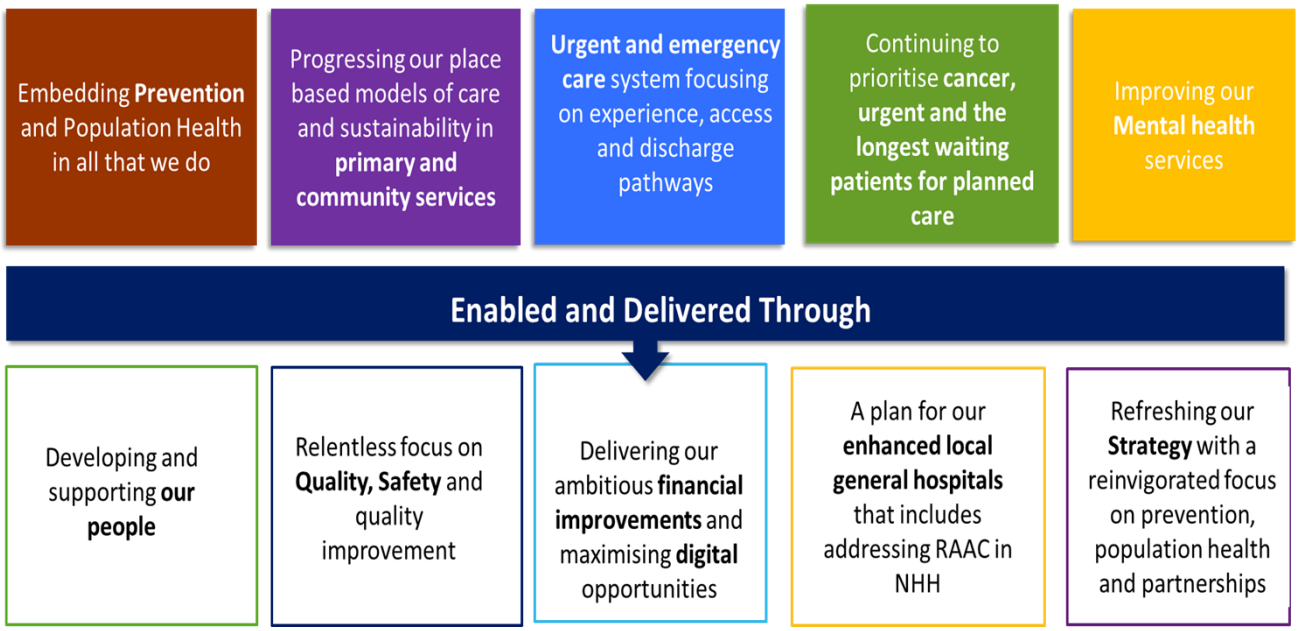
Performance Report

1. Overview from the Chief Executive

Much has been delivered over the past 12 months including achievement of a number of strategic commitments such as a new breast unit, a health and wellbeing centre in Tredegar, and a new endoscopy facility. We have strengthened our approach to embedding quality and quality improvement to support safe and effective care and our staff continue to go above and beyond in difficult circumstances. Despite our continued efforts, the Health Board is now in a higher escalation status under targeted intervention for planning and finance with enhanced monitoring for urgent and emergency care at the Grange University Hospital.

This has been a year with new challenges including industrial action for the first time from our junior doctors. We are still recovering from the impact of the Covid-19 pandemic with many people waiting too long to receive care and treatment and our urgent and emergency care system continues to experience too many delays at a number of points. Mental health also suffered and we have experienced significant demand increases for our services especially for children and adolescents. The rising demand is coupled with rising acuity demonstrated through the rate of working age adults reported in good health on a downward trend since Covid-19 and suspected cancer referrals have continued to exceed 3,500 referrals per month compared with pre-Covid-19 levels of 2,500.

Our plan for 2024/24 sets out the opportunities and priorities across five themes:



Reflections of 2023/24

In 2023/24 we saw:

- Increase demand for urgent primary care
- Ratio of GP/10,000 patients decrease from 5.5 to 4.2
- More people self-presenting to emergency departments and Minor Injury Units
- Patient acuity, linked to the impact of successive lockdowns on our vulnerable populations, has increased, consequently:
  - Number of Emergency admissions has increased
  - Emergency admissions average length of stay is at its highest point ever

- High levels of delayed discharges
- Referrals for suspected cancers have, on average, risen by a third
- Referrals for paediatrics continue to grow
- Referrals for primary care and specialist mental health services (adults and older adults) are well above pre-Covid-19 rates.

Key Achievements over this last year include;

Prevention and Population Health	Led a Gwent-wide partnership action to address inequity and the wider determinants of health as part of 'Building a Fairer Gwent. Sustained compliance with national target of 95% of children receiving 3 doses of the hexavalent '6 in 1' vaccine by age 1. Integrated Wellbeing Networks have supported the development of connected communities. Strengthening community wellbeing and resilience through sustainable place-based care collaboratives, sharing wellbeing resources, prioritising equity and asset-based approaches.
Primary Care Services	Community Pharmacies have demonstrated continued success achieving a 46% increase in common ailment consultations over this year. Continuing to progress the units and levels of patients accessing NHS and Community Dental Services- over this year 325,904 patients have received dental care of which 24,182 were new Patients. All Managed GP practices transferred to independent providers from 1st April 2024
Urgent and Emergency Care System	Embedding of our Same Day Emergency Care service with a weekly average of 138 attendances at Grange University Hospital and 49 at Ysbyty Ystrad Fawr Despite the extreme pressures upon the urgent care system, the performance measures of patients waiting fewer than four hours in Emergency Departments has been maintained during the winter period 73.8% (March 24) against a target of 73% and higher than the Welsh average of 68%. The number and rate of patients waiting over 60 minutes to be transferred to the Emergency Department from an Ambulance has reduced significantly during March 2024 (1,107 – 36.7%) to the lowest levels seen over the last two financial years

Planned Care and Cancer Services	Good progress towards eliminating waits of over 156 weeks for treatment, with 10 patients waiting at the end of March 2024 compared to the March 2023 position of 553 The number of Single Cancer Pathway treatments undertaken has increased by 5.5% over the last 12 months and is continuing to increase month by month. Opening of new Endoscopy suite at Royal Gwent Hospital at the start of November. The impact of this investment has resulted in the number of people waiting over 8 weeks at the end of March 2024 reducing to 1,368 compared to 1,890 (Nov 23) Welcoming our first patients into the Breast Care Unit at Ysbyty Ystrad Fawr as a whole system service delivering the best for our population. Radiology diagnostics patients waiting over 8 weeks has decreased from 3,802 (November 2023) to 1,600 (March 2024).
Mental Health Services	Child and Adolescent Mental Health Services choice referrals have achieved 100% in March 24 compared to 87.5% December 2023 exceeding the national target. Embedding of mental health services in our Neighbourhood Care Networks remains a priority and continues to be piloted in areas with a view to expand across all boroughs. Our new accommodation 'Acer House' for individuals with complex needs had it's official opening on 24th October, in collaboration with United Welsh. Three service users are currently being supported at Acer and are thriving in their new environment. Our new Hiraeth Service aims to offer a whole systems approach to developing a cohesive and consistent care pathway for individuals who present with complex mental health needs, ensuring the ability to engage in the delivery of shared care and promote partnership working.

Our Workforce

We employ 13,082 WTE as at 31st March 2024 and are the largest employer in Gwent. This is an increase from this period last year of 514 WTE. The main increases are within Additional Clinical Services (95wte), Admin & Clerical (64.97wte) and Nursing and Midwifery Registered (123.42wte).

There are also 1,296 WTE colleagues working in independent GP practices in primary care across the region. Our general workforce demographic profile remains relatively

unchanged, as illustrated in figure 5.5. However, 36% of staff are now over 50 years old, which is an increase of 3% and turnover has also reduced from 11.36% to 9.2%. The number of staff we employee will decrease from April 2024 by 135 people due to TUPE Transfers to NHS Executive of national hosted functions and managed GP practices reverting back to independent status.

The highest increase, based on our staff groups, have been in Allied Health Professions (17%) following the introduction of the Physiotherapy MSK services. Other staff groups which have increased include Medical and Dental (10%), mainly as a result of an increase in speciality registrar posts, and Administration and Clerical (5.7%). Clinical Services have increased by 7.5%, Nursing and Midwifery have increased by 4.5% as a result of recruitment campaigns locally and internationally.

Sickness has decreased from 6.9% to 6.2%. Stress, anxiety and depression remains our highest reason for absence and represents 27% of total absence.

Whilst we have made progress in reducing the number of vacancies over the last year, we continue to experience high levels of vacancies across medical specialities and within our registered nursing, pharmacy and Therapy workforce as well as within specific medical specialities. Our priority continues to be recruiting, developing and retaining directly employed staff, recognising the positive impact that a substantive workforce will have in building and sustaining effective teams to provide a positive patient experience.

We are now in year 3 of our People Plan which was agreed and launched in 2022. The plan recognises the importance of a healthy, engaged workforce and aims to support our staff to have a meaningful and positive experience of work.

It is aligned to the commitments of 'Healthier Wales: Our Workforce Strategy for Health and Social Care (2020)'. It also supports the practical actions and enablers outlined in the National Workforce Implementation Plan (2023) underpinning strong inclusive and compassionate leadership and improving retention and recruitment.

In delivering the plan we continue to engage with our Trades Union partners and support ways to develop partnership working. This year we have re-launched divisional partnership forums to complement our corporate forum to build on our commitment to ensuring staff are provided with an opportunity to share views, concerns and to influence plans that affect them.

The Plan focuses on three priority objectives:
1. Staff Health and Wellbeing
2. Employer of Choice
3. Workforce Sustainability and Transformation

Finance

Aneurin Bevan University Health Board, like most health boards across Wales is experiencing significant financial challenges to meet its statutory duty to financially balance over a rolling 3-year period or on an annual basis. Historically the health board has delivered consistent financial balance, however, the Health Board was not

successful in this aim in 2022/23 with a £37m deficit nor in 2023/24 with a £49.8m deficit. The Health Board delivered and improved its out-turn compared to the previous in-year forecast but due to underlying and operational pressures was unable to meet the WG target of reducing to a maximum of £13m deficit.

Despite the out-turn being disappointing it is important to acknowledge the material level of savings achieved in 2023/24 of £43m and this is thanks to the huge efforts of our staff and renewed focus on efficiency that has enabled us to achieve this level of savings.

Moving forward into 2024/25 a deficit is again forecast of c.£48.9m. These levels of deficit, driven by exceptional operational demand pressures and underlying financial challenges, mean the Board is aiming to show an intention to recover to a recurrent financial balance over the next 3-year period.

2. Reporting Requirements

The purpose of the Performance section of this Annual Report 2023/24, as set out in the guidance provided in the NHS Wales 2023/24 Manual for Accounts, is to provide information on Aneurin Bevan University Health Board, its main objectives and strategies and the principal risks that it faces. The requirements are based on the matters required to be dealt with as set out in Chapter 4A of Part 15 of the Companies Act 2006, as adapted in the Financial Reporting Manual and NHS Wales Guidance Manual.

The main features of the performance report flow from the organisation's agreed plan and demonstrate how the Health Board has delivered against these.

It should be noted that the duty of quality came into legal force in April 2023 in line with the Health and Social Care (Quality and Engagement) (Wales) Act 2020. 2023/24 is therefore the first year for the requirement of a Duty of Quality and Duty of Candour report. These reports will be prepared and published separately to this Performance Report. Further information is available in the Annual Accountability Report, Page XX.

3. Aneurin Bevan University Health Board

Aneurin Bevan University Health Board was established in October 2009 and achieved 'University' status in December 2013. The Health Board's principal role is to ensure the effective planning and delivery of our local NHS system, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health and reduce inequalities and achieve the best possible outcomes for our citizens, and in a manner that promotes human rights. To fulfil this role, we are required to work with our partners and stakeholders in the best interests of the population we serve.

As a Health Board, we serve the population of Gwent which reflects the five local authority areas: Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen. The Demographics of Gwent are varied and include rural countryside areas, urban centres and the most easterly of the south Wales valleys.

The Population Needs Assessment for the region can be found here: Demography - Gwentrpb.

The Health Board employs 13,082 WTE as at the end of March 2024 and are the largest employer in Gwent. Our workforce is ageing, as is the demographic profile of our population and the health inequalities of our population are also found within our workforce. 80% of our staff live within our communities. Therefore, it is essential that staff health and wellbeing is a key priority and a feature of our preventative plans.

The Health Board has an annual budget from the Welsh Government of just over £1.6 billion per year from which we plan and deliver services for the population of Gwent. The Health Board, as well as providing services locally, works in partnership to seek to improve health and well-being in the area, particularly through our partnership arrangements to respond to the Social Services and Well-Being (Wales) Act 2014 and the Well Being of Future Generations (Wales) Act 2015.

Detail on how the Health Board is governed is set out within the Accountability Report (Section 2 of the Annual Report and Accounts 2023/24).

4. Integrated Medium Term Plan 2023/24 – Life Course

The vision set out in the IMTP 2023-2026 is to:

> Improve population health and reduce the health inequalities experienced by our communities.

In order to achieve this vision, the IMTP focuses on five life course priorities.



The Outcomes Framework is updated quarterly and, depending on data availability, the latest data is reported for each indicator. It comprises of metrics which should be captured over a longer time period than other routine performance indicators. For the 2023/26 IMTP, the Outcomes Framework was reviewed and aligned, where appropriate, with the newly published Public Health Outcomes Framework. The timescales for indicators vary according to the data source. Indicators are classed as 'Similar' if the percentage change is between -2 and +2 and either 'Improved' or 'Deteriorated' if not. Some of the outcome indicators are reported on an annual basis for the previous year, we have provided the latest position available even those which state 2021 or 2022.

Of the 41 indicators, 27 have either improved or are statistically similar and 14 indicators have deteriorated since the last reporting period.

Type of change	P1 - Every child has the best start in life	P2 - Getting it right for children and young adults	P3 - Adults living healthily and aging well	P4 - Older adults are supported to live well and independently	P5 - Dying well as part of life	Total
Improved	4	2	8	4	1	**19**
Similar	2	1	1	1	3	**8**
Deteriorated	2	2	7	2	1	**14**
Total indicators	**8**	**5**	**16**	**7**	**5**	**41**

Delivering the IMTP Priorities 2023/24



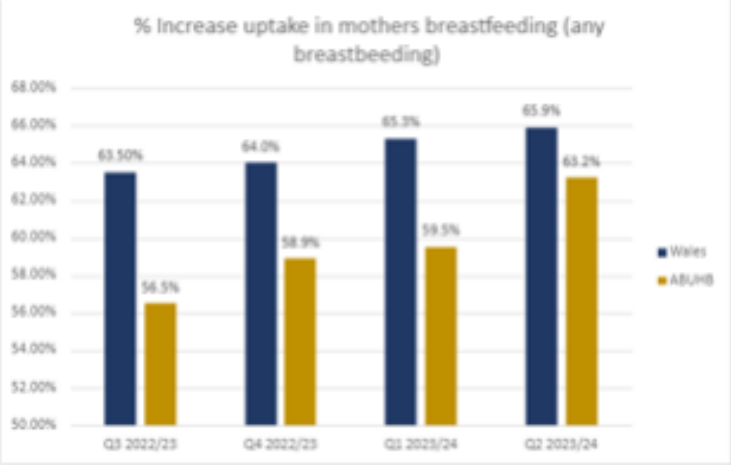
Early childhood experiences, including before birth, are key to ensuring improved health outcomes. The Health Board's IMTP committed to working with partners to take forward actions and activities that have a positive impact on the first 1,000 days of life. The table below sets out three core outcomes to be achieved in this area. Alongside identified measures, this information is used to target actions and identify priorities for the organisation.

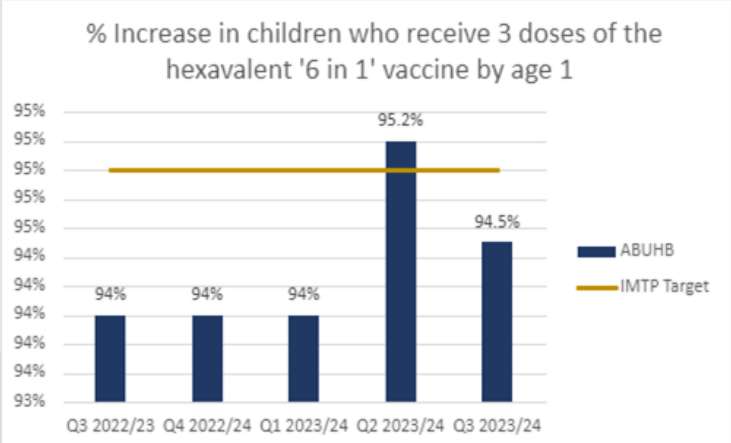
Our Commitments	Our Measures	Indicator Value	Our Performance
Improving Good Health in Pregnancy 	Decrease Low Birth Rates	6.1%	Increase in indicator between 2021 (5.1%) and 2022 (6.1%). In line with the All-Wales average.
	Decrease smoking rates @ birth	13.1%	Decrease from 13.7% in 2021 to 13.1% in 2022 and remains above the all-Wales average.
	Decrease still births	4.5 per 1,000	Increase in stillbirth rates between 2021 (3.9 per 1,000) and 2022 (4.5 per 1,000), however a 10% decrease in stillbirths have been observed over the last 5 years.
Optimising a child's long term potential 	Increase uptake of women breastfeeding	63.2%	Indicator value has improved by 11.6% between Q2 22/23 and Q2 23/24.
	Increase of eligible children with contact at 10-14 days	89.8%	Significant improvement in indicator during the last 12 months (baseline 29.3%).

	Increase of eligible children with contact at 6 months	82.7%	Significant improvement in indicator during the last 12 months (baseline 42.1%).
Increasing childhood immunisation 	% Children who received 2 doses of MMR by age 5	89.3%	Indicator value has remained stable (baseline 90%)
	% Children who receive 3 doses of hexavalent '6in1' vaccine by age 1	94.5%	Indicator value has remained stable (baseline 94%)

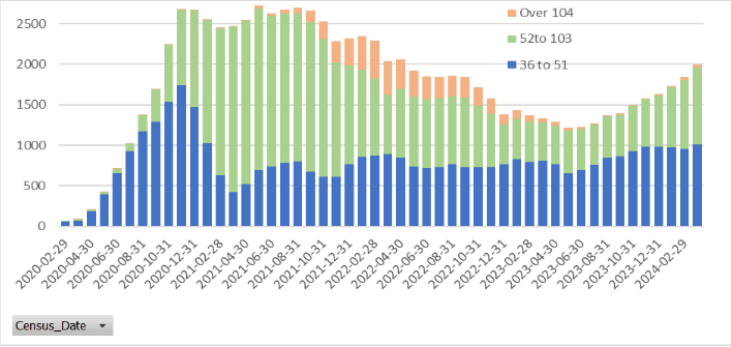
There has been mixed progress in the outcome **'Improving good health in pregnancy'**, with both the low birth rates and still birth rates increasing between 2021 and 2022. Whilst there has been a reduction in the indicator over the previous 3 reporting periods, the rate has increased between 2021 (5.1%) and 2022 (6.1%), which is in line with the all-Wales average. Additionally, still birth rates have increased from 3.9 per 1,000 in 2021 to 4.5 per 1,000 in 2022. Good progress has been made in decreasing smoking rates at birth. The current reported position is 13.1%, which is a decrease from 13.7% in 2021.

There has been an improvement in all three indicators of the outcome **'Optimising a child's long term potential'** with an increase over the last 12 months from 56.6% to 63.2% (Q2 23/24) in breastfeeding rates. As part of the Healthy Wales Child programme, there has been a significant increase over the last 4 quarters in the number of eligible children with contact between 10-14 days at 89.9% (baseline 29.3%) and eligible children with contact at 6 months at 82.7% (baseline 42.1%).





The position in the reported indicators in the outcome **'Increasing childhood immunisation and preventing outbreaks'** has remained broadly stable. Uptake of the complete three-dose course of the hexavalent '6 in 1' vaccination by age 1 is reported at just below 95%, demonstrating strong sustained performance levels and is consistent with national levels. Torfaen and Monmouthshire have the lowest uptake within Gwent with an uptake rate of 90.9%. Blaenau Gwent had the highest uptake rate of 95.1%.



The MMR vaccine protects against three infections – measles, mumps and

rubella. The uptake rate in Gwent of the MMR 2 dose vaccine (age 5 years) was below the uptake for Wales between 2019 and 2021. From 2022 the uptake rate in Gwent and Wales have fallen, with Gwent now sharing the same uptake rate of 89.3% as Wales in quarter 4. Newport has the lowest uptake within Gwent, with a rate of 86.7%. Caerphilly had the highest uptake rate of 92.5%.

The number of children on the Health Board's waiting lists who have been waiting over 36 weeks increased during the pandemic and peaked during the summer of 2021. As of March 2024, there were 495 children waiting over 52 weeks for a new outpatient appointment. There continues to be focused efforts to reduce paediatric waiting times and consequently, intensive plans have been developed to reduce and maintain the waiting time for first outpatient appointments across all specialities.

Priority 2

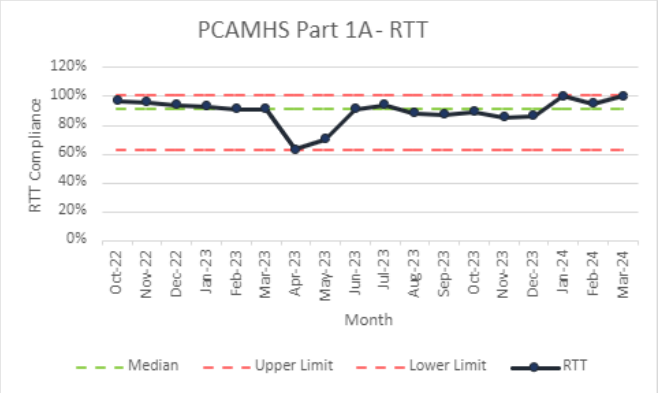
Getting it right for children and young adults

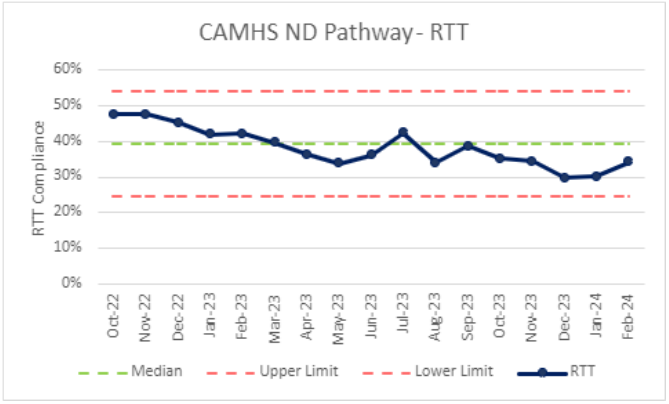
Nurturing future generations is essential for our communities. There is strong evidence that healthy behaviours in childhood impact throughout life; therefore, targeting actions to improve outcomes in these areas has a long-lasting impact on delivery. Young adult mental health is a Ministerial Priority area with CAMHS a focus in the national performance framework.

Our Commitments	Our Measures	Indicator Value	Our Performance
Improve mental health resilience 	Decrease in 4-week CAMHS waiting lists	100.0%	Indicator has improved significantly since last reporting period. National target of 80% remains achieved at 100% compliance.
	Increased compliance in neurodevelopmental (SCAN) waiting list	34.3%	Indicator has deteriorated over the last 12 months (baseline, 39.7%)
Support being a healthy weight 	Increase in physical activity (for at least 60 minutes a day) in adolescents	15.1%	Indicator is lower than the Welsh average of 16.2% and has decreased over the last 12 months (baseline, 15.9%).
Improve healthy lifestyle behaviours 	Decrease in adolescents using alcohol	40.9%	Similar to Mar 23 baseline (40.7%), however indicator is higher than the Welsh average of 40.2%.
	Decrease in adolescents drinking sugary drinks once a day or more	18.5%	Indicator is higher has improved from 19.4% (Mar 23 baseline) to 18.5%.

Progress within the **'Improve Mental health Resilience in Children and Young Adults'** outcome remains mixed. The CAMHS Neuro-developmental (ND) Service remains committed to achieving the 80% target of completing ND assessments within 26 weeks. 2023/24 has seen a continued demand of referrals requesting consideration of an ND assessment. There are on average 220 new referrals a month which is a 200% increase on the monthly average for 2019/20 and this challenge has resulted in an RTT compliance for the end of February 2023 of 34.3%. A recovery plan was implemented

in April 2023 to be able to support the current waiting lists across the 0-18 years pathway by separating the cohorts of 0-5 years and the 5-18 years.





PCAMHS 1a performance against the ministerial target of 80% compliance has remained steady since 2022. As of March 2024, the reported position increased significantly to 100%, surpassing the ministerial target. However, Part 1b remains significantly off track at 7.5% compliance (March 2024). Despite workforce constraints, the waiting list is reducing. CAMHS Part 2 RTT has seen increased compliance since April 2023, however there is a slight decrease in the reported March 2024 position at 72.4%.

Within Gwent, the percentage of adolescents participating in at least 60 minutes of exercise a day is reported at 15.1%, a reduction from 15.6% the previous year. Physical activity diminishes with age, from 20.7% (age 11) to 12.4% (16) and by gender with 20.7% reported amongst males and 11.9% amongst females. Additionally, there is a reported variation based on deprivation, with those living in a more affluent area more likely to engage in exercise (18%) compared to those in the least affluent areas (14%).

Within the '**Improving healthy lifestyle behaviours'** outcome the indicators 'percentage of adolescents using alcohol' and 'drinking sugary drinks once a day or more' have both reported higher rates than the all Wales average. The average percentage of adolescents drinking sugary drinks once a day or more is currently 18.5% compared to the all Wales average of 16.4%.

People who begin drinking early in life run the risk of developing serious alcohol problems, including alcoholism, later in life. They are also at greater risk for a variety of adverse consequences and poor performance in school. The average percentage of adolescents using alcohol is currently 40.9% compared to the all Wales average of 40.2% and this rate rapidly increases by age, increasing from 15.2% at the age of 11 to 71.8% by the age of 16.

Priority 3

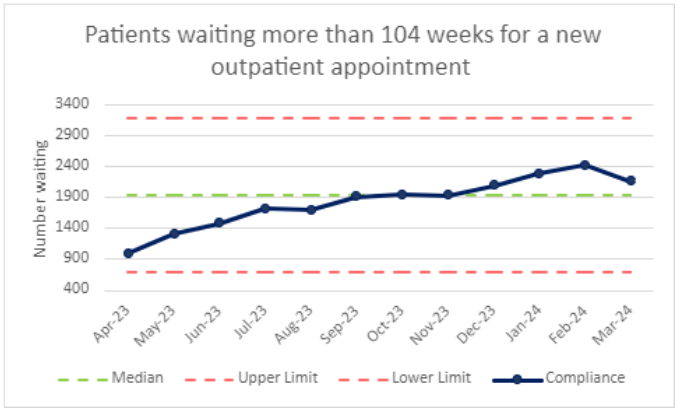
Adults living healthily and ageing well

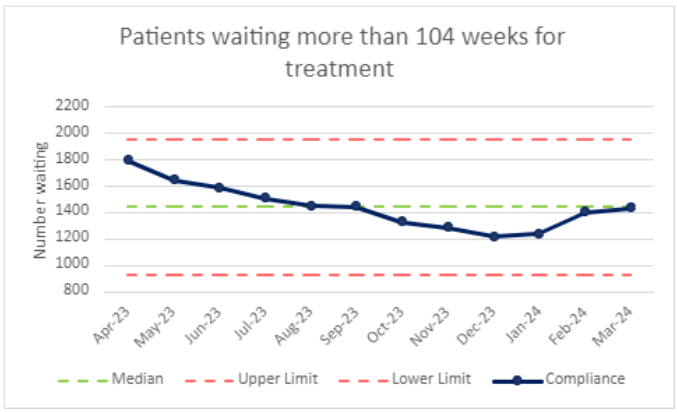
Our ambition is for citizens to enjoy a high quality of life and to be empowered to take responsibility for their own health and care. A significant number of measures fall within this area, particularly in relation to maximising an individual's time. The outcomes and performance set out below underpin the work of the priority programmes and in particular the work of the Six Goals for Urgent and Emergency Care, Planned Care and Mental Health.

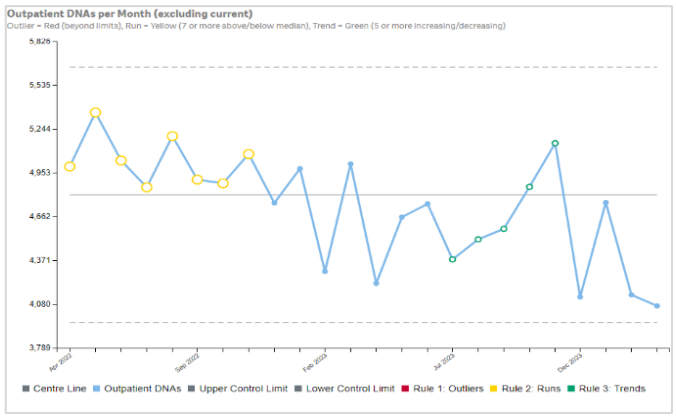
Our Commitments	Our Measures	Indicator Value	Our Performance
Maximise an individuals time 	Reduction in the number of patients waiting more than 36 weeks for treatment	42,980	Indicator value has increased over the last 12 months (baseline, 32,202)
	Reduction in the number of patients waiting for a follow-up outpatient appointment	134,784	Indicator value has increased by 11.6% between Mar 23 and Mar 24.
	Increase in Urgent Primary Care Contacts	9,916	Significant increase in monthly contacts over the last 12 months (baseline, 5,456)
	Reduction of ambulance handovers over 1 hour	691	Significant reduction (Mar 23, 1,497) and improving trend.
	Reduction in patients never waiting in ED over 16 hours	399	Decrease in the indicator value for the last year (Mar 23, 498)
	Reduction in time for patients to be seen by first clinician	2.0 hours	Improving trend overserved during 23/24 (Mar 23, 2.3 hours)
	Reduction in time for bed allocation from request	12.3 hours	Improvement in metric from 13.9 hrs (Mar 23) to 12.3 hrs (Mar 24)
Adults living healthily and aging well 	Increase in adults meeting physical activity guidelines	49.9%	Since Covid-19, there has been a decrease in physical activity. Reduction from 52% (20/21 baseline) to 49.9% (22/23)
	Decrease in the % of adults smoking	13.6%	IMTP target met, however there is an observed increase in the percentage of adults smoking between 21/22 (12.9% and 22/23 (13.6%).
	Increase in working age adults of healthy weight	33.4%	For the first time since Covid-19, there has been a 14% increase. However, remains below the all-Wales average of 36.1%.
	Increase in working age adults in good or very good health	69.5%	Both the ABUHB and All Wales average have seen a decreasing trend over since Covid-19 (baseline 76.9%)
	Increase uptake of National Screening Programmes	70.2%	Improvements in indicator value observed (baseline, 64.2%)
Improve mental health resilience 	Increase in life satisfaction among working age adults	79.2%	Indicator has improved between 21/22 (76.4%) and 22/23 (79.2%)
	Increase in percentage of Health Board residents in receipt of secondary mental health services who have a valid care and treatment plan (18 years and over)	67.7%	Measure has deteriorated during the last 12 months (baseline, 75%)
Maximise cancer outcomes 	Increased compliance of the number of patients starting their first definitive cancer treatment within 62 days from point of suspicion	60.8%	Improvement in indicator since Mar 23 (56%) and Mar 24 (60.8%).
	Increase in 5 year cancer survival	58.6%	Significant improvement in indicator between reporting periods from 54% (2015-19) to 58.6% (2016-20)

Maximising an Individual's Time-Planned Care

Maximising an individual's time is a core element of planned care. During the Junior Doctor Industrial Action in Quarter 4, a total of Junior Doctor Industrial Action on the 25th-29th March 2024, a total of 3,298 outpatient appointments and 508 treatments were cancelled and this loss of capacity has had an impact upon performance levels. The Health Board has made good progress towards eliminating waits of over 156 weeks, with 10 patients waiting at the end of March 2024 compared to the March 2023 position of 553. Improvements have also been made with 104 week waits for treatment which has reduced from 1,935 in March 2023 to 1,430 at the end of March 2024. Despite this reduction, the Health Board remains off track to meet the Quarter 4 104-week treatment trajectories by 1,184.







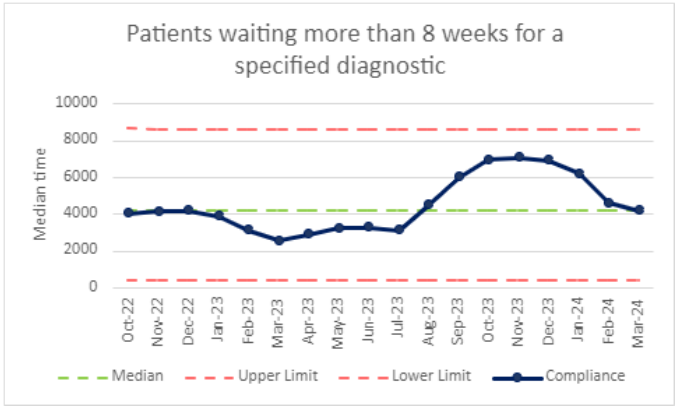
There is a particular challenge within ENT where demand has outstripped capacity, along with reduced outpatient capacity. A 'GP gatekeeper model' has been introduced and is being piloted to review demand with the purpose of managing demand in the most appropriate way, and early indicators show that the additions to the waiting list have reduced. Ophthalmology have launched a new technician diagnostic hub to address the backlog of Glaucoma patients on the follow-up waiting list, with a particular focus on those waiting over 100% past their follow-up target date.

Improvement in outpatient performance remains essential to make the most of an individual's time and is a core focus of the Planned Care Programme. At the end of March 2024, there were 2,169 patients waiting over 104 weeks for a first outpatient appointment. There is mixed progress across specialities with ENT, Orthopaedics and Ophthalmology currently behind trajectory. There are extensive recovery plans in place across ENT and Urology including a clinical review of patients on the waiting list along with other solutions (e.g. audiology) supporting ENT and a focus on improving treat in turn prioritisation across all specialities. However, despite plans being implemented it is likely to take time to recover the 104-week position, although significant improvements have been noted within the ENT 52-week position due to the implementation of the recovery plan.

The outpatient transformation programme is focussing on the outpatient Did Not Attend (DNA) plan, of which the current rate for new outpatient appointments has been sustained at 6.1% (4,070) in March 2024. Additionally, the programme is continuing to work alongside finance and divisional teams, with a particular focus to further explore opportunities of virtual activity to meet the needs of those waiting for an appointment.

Maximising an Individual's Time - Diagnostics

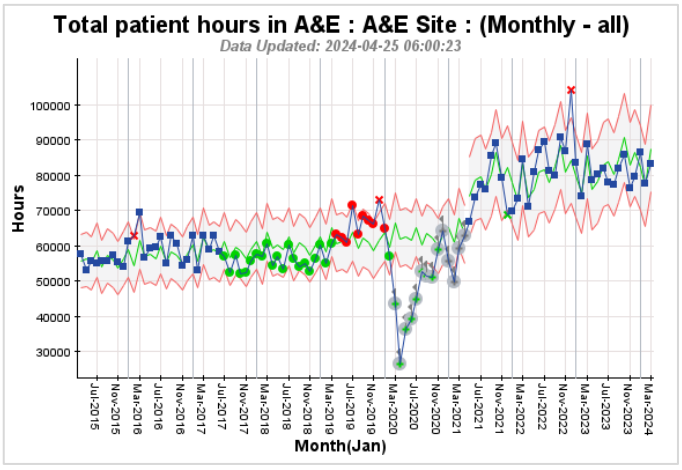
The overall eight week diagnostic breach position has seen an improvement since November 2023. Key areas in diagnostics include:

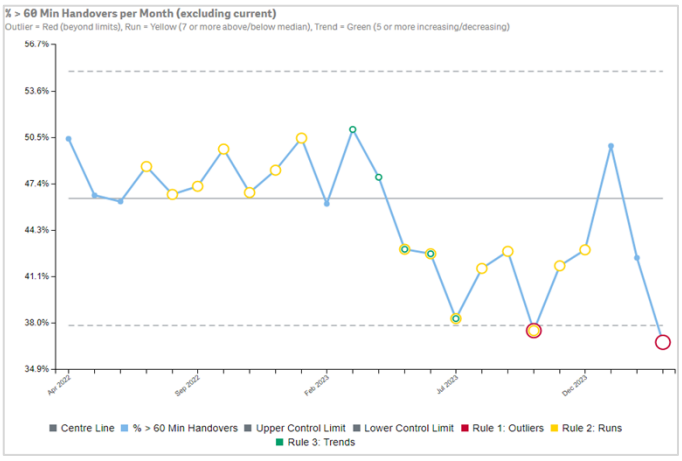


- Royal Gwent Hospital endoscopy unit opened in November 2023, with the purpose to sustain services and reduce backlog of those waiting. The impact of this investments has resulted in the number of people waiting at the end of March 2024 reducing to 1,368, compared to 2,061 (Mar 23);
- Radiology diagnostics patients waiting over 8 weeks have increased from 321 (Mar 23) to 1,155 (Mar 2024);
- Cardiology position has been maintained at 206 breaches in March 2024.

Maximising an Individual's Time- Urgent Care

Urgent Care services continue be under significant pressure both nationally, regionally and locally, making delivering timely care challenging. There has been increasing demand for urgent primary care, increased ambulance call demand, increasing numbers of self-presenters at Emergency Departments and Minor Injury Units, increased acuity, increased bed occupancy for emergency care and high levels of delayed discharges linked with significant social care workforce challenges.





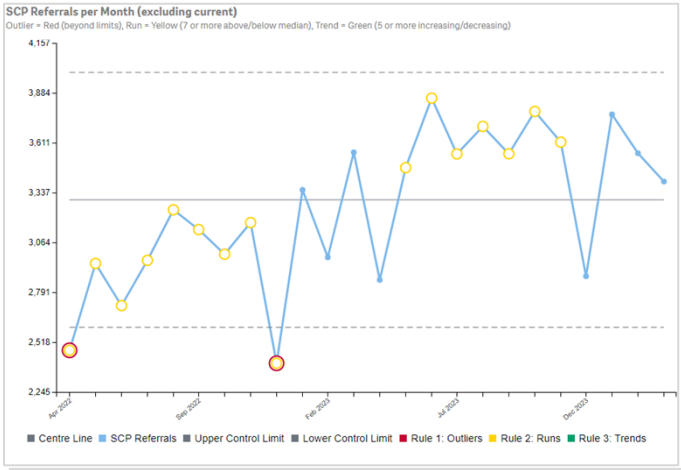
Over the last financial year, there have been on average 516 daily attendances to the Emergency Department or a Minor Injury Unit, compared to 505 during the previous year, and the pressure on the urgent care system has resulted in patients staying in hospital for longer. The average time from arrival to departure in the GUH Emergency Department continues to be above target, with the total number of patient hours spent in A&E increasing significantly above pre-covid levels as the chart above demonstrates. The number and rate of patients waiting over 60 minutes to be

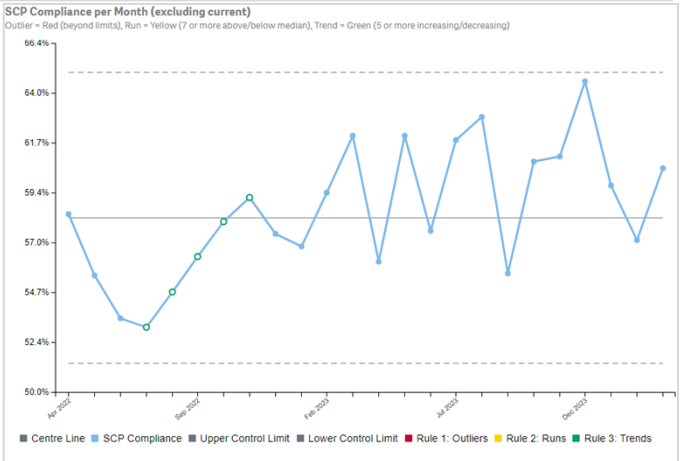
transferred to the Emergency Department from an Ambulance have decreased significantly from 1,597 in March 2023 to 691 in March 2024 and is the lowest level seen over the last two financial years. Whilst this remains high, as a result of poor flow through the system, there has been a concerted effort to decrease the number of delayed ambulance handovers.

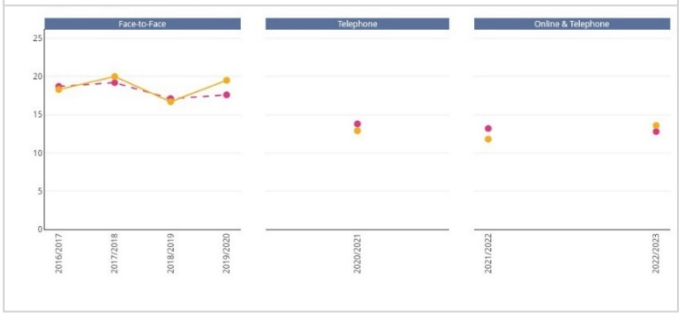
Despite the extreme pressures upon the urgent care system, the performance measures of patients waiting fewer than four hours in ED has been maintained during the winter period and is currently reported at 73.8% (March 24) against a trajectory of 73%. The most recent national performance data reports that the Health Board's performance is higher than the Welsh average of 68%. Patients waiting over 12 hours in Emergency Departments was 1,477 in March 2024, compared to 1,606 in March 2023.

Maximising cancer outcomes

Overall, there has been significant improvement in the rate of five-year cancer survival reported over the last 10 years. However, whilst statistically similar, a slight decrease of 0.8% has been observed and cancer survival remains below the Welsh average for the third consecutive year.







Compliance against the 62-day target for definitive cancer treatment has incurring during 2023/24 from 58.2% at the end of March 2023, to 60.8% in March 2024. This is behind the performance ambition set in the IMTP. Drivers for this include the significant increase in demand alongside the focus on reducing the over 62 day waits, which will affect compliance. Significant increases in demand relating to the suspected cancer referrals have continued to exceed 3,500 referrals per month compared to pre-covid levels of 2,500.

The number of SCP treatments undertaken has increased by 5.5% over the last 12 months and is continuing to increase month by month. Despite the pressures of increased demand and capacity challenges, there has been an improving position in the number of patients waiting over 62 days over the last 6 months, reducing 346 at the end of March 2024.

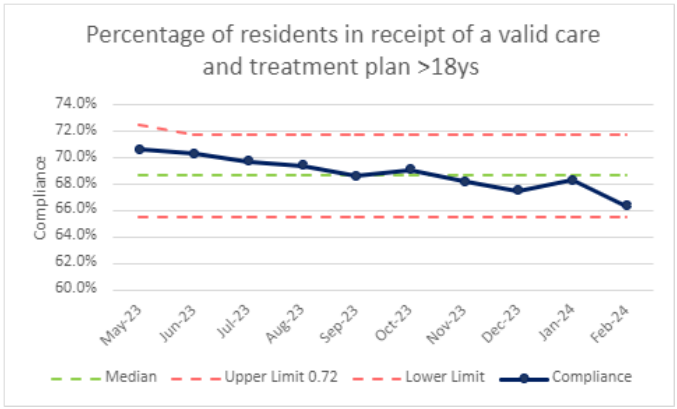
Adults living healthily and aging well.

Lifestyle factors such as diet and physical activity are closely associated with chronic health conditions such as cancer, diabetes, obesity and cardiovascular disease. The

outcome 'Adults living healthily and aging well' has seen a deterioration in the measure of the percentage of adults smoking. The rate has increased to 13.6% in 2022/23 compared to 11.8% in 2021/22 and is higher than the national average.

Over the next year the Health Board will be developing a cardiovascular disease risk assessment programme to tackle preventable cardiovascular disease focusing on behavioural risk factors including smoking which is the second highest risk factor following hypertension. This will be a holistic assessment and support model deployed across the neighbour care networks in Gwent.

Mental Health in Working Adults



Mental wellbeing and life satisfaction result in better subsequent health outcomes on some physical health indicators, health behaviours and psychosocial indications, including depressive symptoms. Mental wellbeing remains a key priority for the organisation and sustained performance levels have been observed in the 'improved mental health resilience in adults' outcome. As of Feb 2024, 68% of Health Board residents over 18 in receipt of secondary mental health services have a valid care and treatment plan.

There are concerns on the provision of assessment by mental health service within 28 days from referral which is currently at 17.1% (Feb 24) and interventions less than 28 days from assessment which is currently 7.3% both areas are being addressed in a 90-day action plan monitored by Executive Committee to ensure targeted assurance.

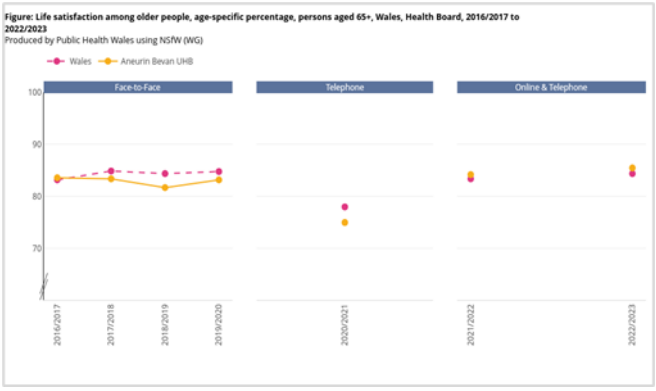
Priority 4

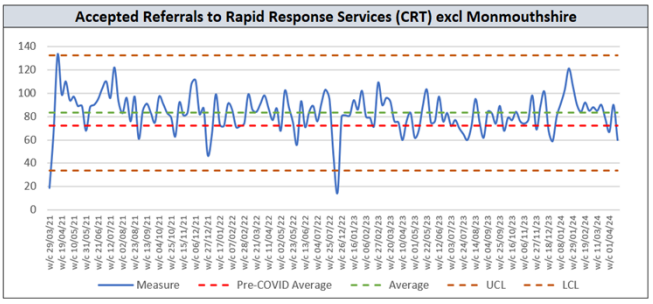
Older adults are supported to

Supporting older adults to live well and independently is a core component of the Health Boards' plan for a sustainable health and care system. We know we need to deliver improvement for this section of our population in our service offer. Within the Urgent and Emergency Care 6 Goals programme there is prioritisation in Goals 1 and 2 for redesigning services for older people.

Our Commitments	Our Measures	Indicator Value	Our Performance
Prevention and keeping older adults well 	Increase in older people free from limiting long term illness	45.1%	Improvement in indicator from 43.3% (20/21) to 45.1% (22/23).
	Increase in life satisfaction among older people	85.5%	Increase in indicator over the last 3 financial years and remains above the all Wales average of 84.4%
	Increase in older people of healthy weight	41.2%	Increase in indicator from 38.7% (20/21) to 41.2% (22/23), surpassing the all Wales average of 39.6%.
Delivering care closer to home 	Increase in accepted referrals to Rapid Response Services (CRT)	377	Improvement in indicator over the last 12 months (baseline 326)
	Increase in accepted referrals to Reablement & Falls Services (CRT)	76	Deterioration in referrals over the financial year (Mar 23, 214)
Reducing admissions and time spent in hospital 	Reduction in the number of Emergency Admissions >65 years of age	1738	Significant increase in the number of emergency admissions from 1,427 (Mar 23) to 1,738 (Mar 24)
	Decrease (from 65 - 55%) in LOS over 21 days	55%	Statistically similar to last reported position (56% Mar 23)

Good progress has been made in the **'Prevention and keeping older adults well'** outcome with an improvement in all 3 indicator values. Firstly, there has been an increase observed in life satisfaction reported amongst older people from 84.2% (2021/22) to 85.5% (2022/23) and this remains above the all-Wales average of 84.4%. Additionally, there has been a significant increase in the percentage of older people of healthy weight. This has increased from 38.7% (20/21) to 41.2% (2022/23) and has also surpassed the all-Wales average of 39.6%. Finally, there has been a observed improvement in the percentage of older people free from limiting long term illness, increasing from 43.3% (20/22) to 45.1% (22/23).





The indicator values for '**Delivering Care Closer to Home'** outcome are mixed. As of March 2024, there were 377 accepted referrals to the Rapid Response Services and 76 to the Reablement & Falls Services. Goal 1 of the Urgent & Emergency Care Transformation programme has progressed the development of redesign of frailty services, including a Nurse-led Acute Frailty Response team at the Grange University Hospital (GUH) front door and the expansion and capacity build across Community Resource Teams via RPB funding to enable people to remain at (or close to) home, where this is safe and appropriate.

The outcome **'Reducing admissions and time spent in hospital'** has also seen mixed progress, with the number of emergency admissions for over 65 years of age increasing, throughout the year and particularly during Quarter 4 and is currently reported at 1,738 at the end of March 2024. The indicator 'decrease in the length of stay over 21 days' has remained statistically similar to the previous reported position of 55% in March 2024, which has resulted in the IMTP target of 55% being met.

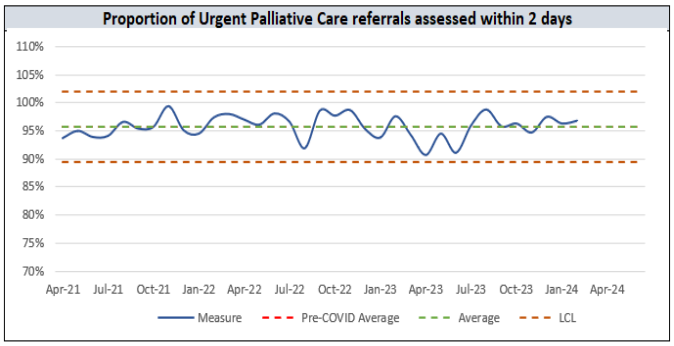
Priority 5

Dying well as part of life

The IMTP sets out the commitment to continuously improve what we do to meet the need of people of all ages who are at the end of life. The measures represent indicators to support the organisation's understanding of how it is delivering in this area to support the population to die in their place of choice and have access to good care.

Our Commitments	Our Measures	Indicator Value	Our Performance
Improved end of life care experience 	Decrease in inpatient mortality rate	2.1%	Measure remains statistically similar (Mar 23, 2.1%)
	Reduction in complaints	21	Deterioration in indicator from 11 complaints received during 2021/22 to 21 during 2022/23.
Improved planning and provision of end of life care 	Increase in referrals to Palliative Care Services	183	Indicator has increased by 17% between reporting periods (baseline, 171)
	Increase in proportion of Urgent Palliative Care referrals assessed within 2 days	97%	Despite significant increase in referrals, the proportion of Urgent Palliative Care referrals assessed within 2 days has been sustain and compliance with target remains (baseline, 99%)

Progress against all two of the outcomes of this life course priority vary. For the outcome measure **'Improve care at the end of life'**, it is recognised that the relationship between mortality rates and the quality of patient care is a complex one. For this reason, the indicator 'decrease inpatient mortality rate' is used as a measure and trigger for further investigation, understanding that it may not indicate any deficiency in the quality of care. The rate in inpatient mortality has remained statistically similar and is reported at 2.1% at the end of March 24.

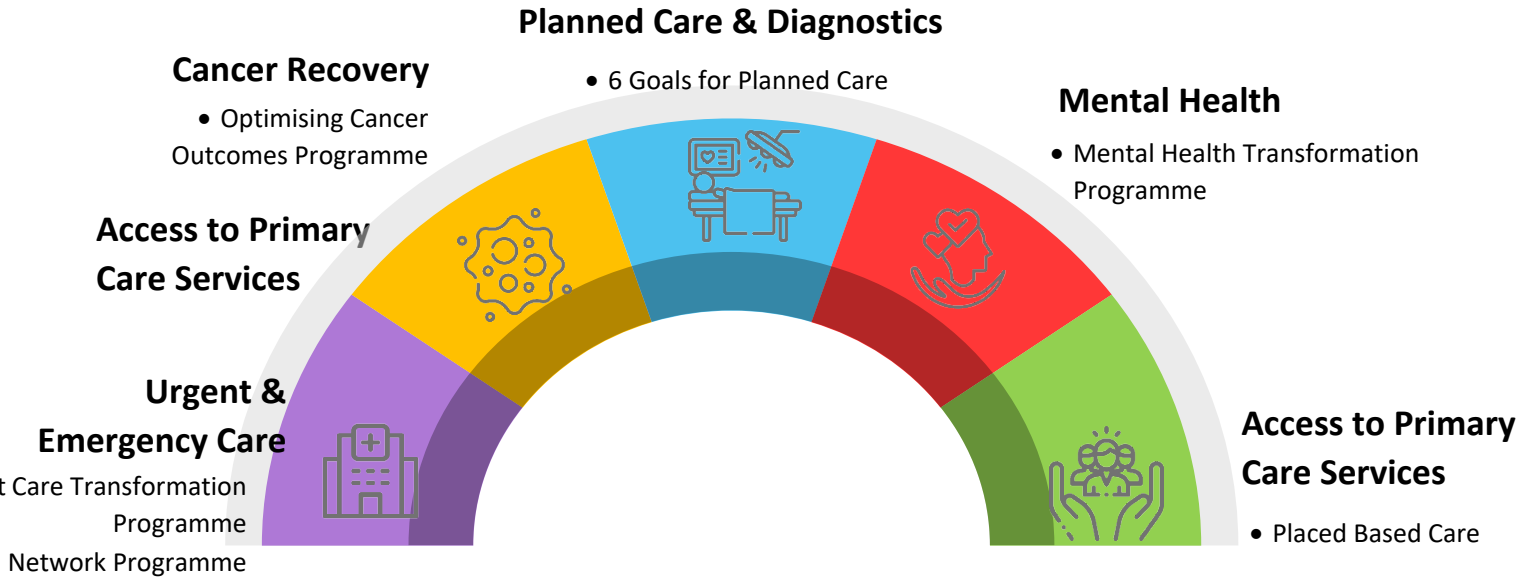


Good progress has been made within the outcome **'Improved planning and provision of end-of-life care'**, with the number of referrals to palliative care services increasing from 171 (Mar 2023) to 183 (Feb 2024). Despite this increase, the proportion of urgent palliative care referrals assessed within 2 days has been sustained at 97% and the IMTP target remains met. Over the next year we will implement the National Bereavement Pathway for Wales,

including the development of a single point of contact for death and offer surveys to bereaved people to obtain feedback on the quality of support received.

5. Integrated Medium Term Plan 2023/24 – Priority Programmes

This chapter of the report updates on delivery against the Ministerial Priorities and Clinical Futures programmes. There is a high degree of synergy between the Ministerial Priorities for 2023/24 that are designed to support a swift recovery of business as usual and to reduce growing waiting lists and waiting times. All priorities are underpinned by a focus on quality, safety and prevention as a part of the planned activity, with good medical outcomes at the heart of NHS services.



Urgent and Emergency Care

Prior to the pandemic, the situation in Emergency Departments was increasingly difficult, with demand soaring and the percentage of people being seen within the four-hour target reaching an all-time low over the 2019/20 winter. Since the start of the pandemic, ED attendance decreased significantly which led to performance improvements. Since lockdown eased, demand has steadily risen, and a greater number of people with serious problems are presenting themselves in our urgent and emergency care system.

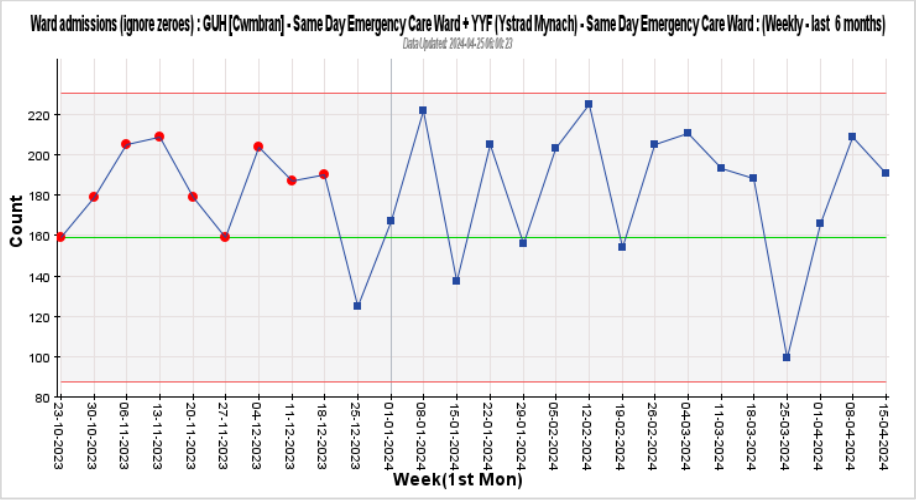
Some areas of progress include:

Goal 1:

- **Acute Frailty Response (AFR)** Team launched and substantive staff recruitment underway.
- **Community Response Team (CRT)** Work commenced to bring together GUH front door teams including service delivery and evaluation (AFR, CAATT, Home First, AMU SAS Dr).
- **Care Home** workstream established and Luscii technology pilot in care homes agreed (pending start date).

Goals 2, 3 and 4:

- **Same Day Emergency Care** patient volume sustained at an average of 138 weekly attendances at GUH and 49 at YYF.
- **Reducing Conveyance** Collaborative Workshop with WAST held on 19th February 2024 to discuss opportunities including strengthening falls response in community and a 111 first pathway.



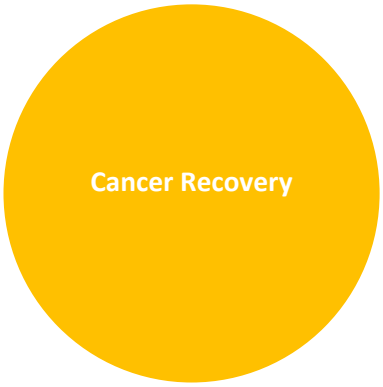
- **Urgent Primary Care Demand:** Analysis completed to understand the increase in demand from Primary Care at start of 2024. Single phone number for Urgent Care launched February 2024.
- **Flow Centre** Transitioning to a Nurse led model.
- **Fracture Liaison Service** development funding received.

Goals 5 & 6:

- **Step Down Improvement** Optimising Hospital Flow Framework Refresher training being delivered as part of a development programme. Patient Safety Events continue at GUH with a specific focus on patients planned for step down.
- **Hospital 2 Home** team now fully appointed, working with Monmouthshire and Newport Localities.
- **Discharge/Transfer Lounge** Royal Gwent Hospital (RGH) Discharge Lounge Capital works complete and leadership role appointed. NHH Discharge Lounge now operating under new pull model. Modelling undertaken for GUH Discharge Lounge
- **Optimising Patient Flow** Discharge to Assess digital solution piloted across three wards, wider roll out now underway. Two Future Flow Design workshops delivered, and two areas of work identified – bed allocation and workforce model.

Enhanced Local General Hospitals:

- Relocation of two wards and repurpose of one ward at St Woolos Hospital (SWH) to RGH, end of February 2024.



Cancer outcomes need to be improved. The Single Cancer Pathway, supported by Optimal Cancer Pathways for individual tumour sites, provides the roadmap to shorten diagnostic and treatment pathways once a person is suspected as having cancer. The Cancer Strategy, Delivering a Vision 202-25, sets out the broader context with prevention, early detection, patient experience, living and dying with cancer, cancer research and access to novel therapies also key components to transforming cancer services for our population.

Some areas of progress include:

- **YYF Breast Centre** on Monday 5th February 2024, the brand-new Breast Care Unit at Ysbyty Ystrad Fawr welcomed Gwent patients for the very first time
- **Acute Oncology Service** Bevan Commission project between VCC treatment helpline and ABUHB Acute Oncology Service and SDEC teams has been completed and the report and poster submitted
- **Public Health Inequalities** Workshop was held in January and subsequent paper and Inequalities Action Plan have been produced and agreed by Cancer Board in March 2024.
- **SACT Outreach Partnership** A SACT Outreach Workshop was held between with Velindre Cancer Centre in February 2024.
- **Enhanced Psychological Programme for those living with and beyond cancer/person** successfully recruited a Clinical Psychology Lead in March 2024.
- **Radiotherapy Satellite Centre** Estates and Facilities meeting between the Health Board and VCC to discuss operational modelling held.



During the pandemic, services had to be paused to respond to the immediate demands and challenges of COVID-19 and capacity has been reduced by infection prevention and control requirements. As a result, the number of people waiting – and the time people are waiting – for planned care services are now longer than ever. This position is further exacerbated by those who did not access health care during the pandemic and in addition to the backlog of patients known to the services there is a potentially significant cohort of 'unreferred demand'.

Some areas of progress include:

- **Health Pathways** launched on 19th April 2024 with first 50 pathways. Phase 2 pathways allocated, to be reviewed against national and local priorities.
- **Patient Access and Activation** Welsh Government funding confirmed for 2024/25. Recruitment of Call Handlers ongoing, along with communication to raise awareness of the service.

- **Outpatients** Welsh Government part-funded Treatment Unit until March 2024. Business case drafted for full funding of the unit. Work ongoing to progress Automated Clinical Booking System.
- **Diagnostics** Continuing to engage in regional diagnostic developments
- **Theatres** Embedding new dashboard through scheduling meetings and performance reporting.
- **Planned Care Academy** 3 workstreams are progressing objectives (e.g. draft training plan has been developed)



The detrimental impact of COVID-19 on the mental health and wellbeing of our population has been significant. Demand is likely to exceed capacity threefold over the next three to five years. Demand for mental health and CAMHs services is sharply increasing and we need to find ways of supporting people earlier to better support crisis prevention and recovery.

Some areas of progress include:

- All planned quarter 4 milestones for **implementation of 111 press 2** are off track due to capacity constraints impacting on delivery of service improvements. Emergency funding from Welsh Government is being used to deliver core service. The move of the service into new accommodation is being considered as part of wider organisational work on estates.
- **Hub based model** operating across Neighbourhood Care Network (NCN) areas is significantly off track as funding constraints impacted estates availability. At present this is on hold until other avenues that require less investment can be agreed.
- The Welsh Community Care Information Systems (WCCIS) backlog continues to be reduced.
- Further progressed is being made regarding the **Matched Care Model.**
- Weekly performance meetings continue and are responsive to the demand ensuring effective use of capacity.
- CAMHs have surpassed 80% compliance for **CHOICE (New referrals) to assessment within 28 days** for Quarter 4 at 100% compliance. Monthly demand and capacity review undertaken to ensure that job plans have sufficient capacity to meet CHOICE demand. Continued implementation of workforce plans including efficient recruitment into vacancies.
- PCAMHS is continuing to flex capacity to meet the **Initial Assessment Part 1A 80% target** with March 24 position 78.12% despite significant vacancies and workforce deficits.
- **Under 18s Initial Assessment Part 1B recovery plan** continues to be implemented making reasonable progress.



The Primary Care Model for Wales set out how primary and community health services will work within the whole Public sector system to deliver Place-Based Care. Collaborative work is at the core of this bringing together local health and care services to ensure care is better coordinated to provide care closest to home and promote the wellbeing of people and communities.

Some areas of progress include:

- **Professional Collaboratives** formalised governance arrangements for professional collaborative leads and agreed priorities for each professional collaborate.
- **Access Standard** – 100% of GP practices have reported access standards quarterly.
- **Community Pharmacies** has demonstrated continued success achieving a 46% increase in common ailment consultations over this year.
- Continuing to progress the units and levels of patients accessing NHS and **Community Dental Services-** over this year 325,904 patients have received dental care of which 24,182 were new Patients. Development of new dental contract as part of Tredegar Development is currently in progress and on track to open on 1st April 2024.
- Supported the roll out of Wales National Workforce and Reporting System (WNWRS).
- Development of a **Palliative Care** Medical Champions Programme
- **Pharmacy** career pathways defined and scheduling of phase 1 undergraduate MPharm student placement scheme
- **Urgent Primary Care** contacts increased by 22% from 2022-23 to 2023-24
- All Managed **GP practices** transferred to independent providers from 1st April 2024
- Wellbeing collaboratives continues to be developed alongside **NCN**s.

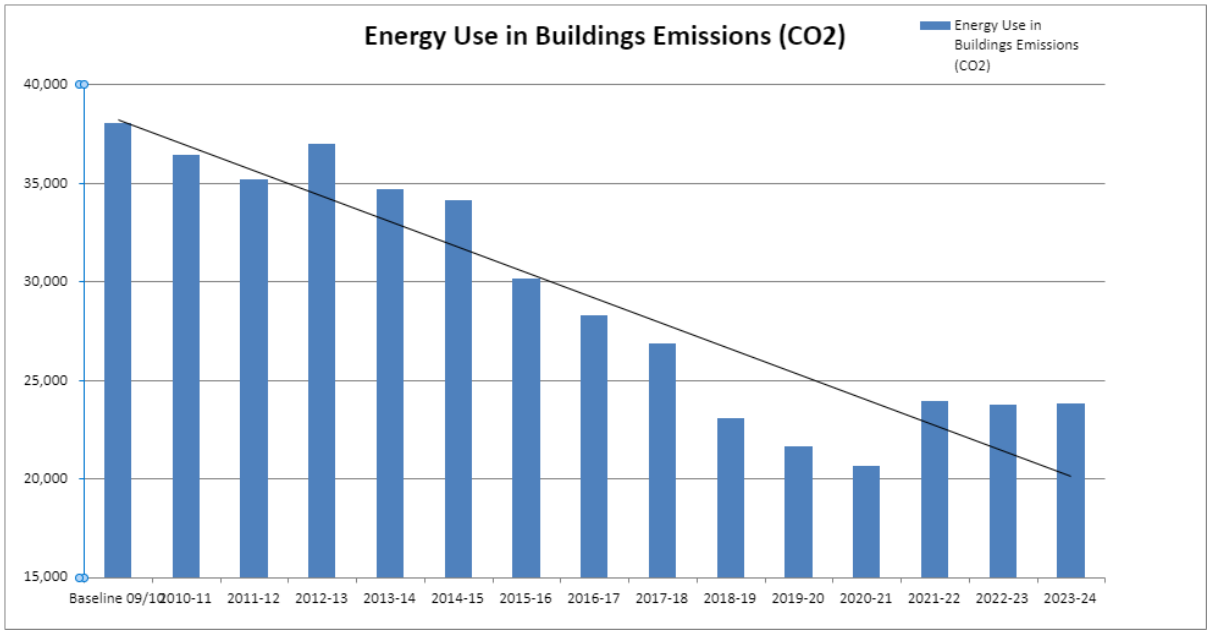
Sustainability and Carbon Reduction Plans



The Health Board continues to align its activities to complement and make progress towards the objectives and targets set out in the NHS Wales Decarbonisation Strategic Delivery Plan, published by Welsh Government in 2021. The Plan responds to the declaration of the climate emergency in 2019 and the ambition of Welsh Ministers for the Welsh public sector to be net zero by 2030.

During 2022/23 the Health Board established its Decarbonisation Programme Board, chaired by the Executive Director for Finance and Procurement. Four working groups are now well established, each working group having a suite of the national initiatives assigned to them to take forward and develop associated projects. In 2023/24, several workshops were held with the working groups to inform the development of the future 24/25 decarbonisation work plan.

Since 2010, the Health Board has made consistent reductions in carbon emissions from its building's portfolio. Up to this year (2023/24) the emissions from energy use in buildings has been cut by 37%, equating to a total saving of 14,241 tonnes of carbon.



Since 2020, and the early opening of the Grange University Hospital in response to the COVID-19 pandemic and with the opening of a new Hazardous Substances Decontamination Unit in Llanfrechfa as well as the new Bevan Health & Well Being Centre in Tredegar and the Unified Breast Unit located at Ysbyty Ystrad Fawr; mean that energy use and carbon emissions from buildings have increased as the size of the estate and clinical activity increases across the Health Board and premises occupancy returns to pre-pandemic levels. By making efficiencies in the operation of the building services (lighting, ventilation, heating, and hot water) throughout the year we have mitigated the emissions increase to 0.3% this year.

During 2023/24 the Estates and Facilities Division made considerable progress with its energy performance contract development. Through competitive tender the ReFit Cymru Programme contract was awarded to Vital Energi Ltd. This long-term partnership has the potential to deliver significant investment in low-carbon and renewable energy projects across the main hospital and community premises in the coming years and through several phases of work. The ReFit Programme will contribute significant carbon savings towards the decarbonisation ambitions of the Health Board.

The Facilities Division during 23/24 were able to transition 13 traditional diesel fleet vehicles over to electric van equivalents. These were rolled out to hospital sites during the latter part of the financial year.

During 23/24 the Health Board was able to complete Initiative 9 of the NHS Wales Decarbonisation Strategic Delivery Plan – to appoint a full time Building Management Systems Officer. Throughout the year we have been working hard to optimise hospital building services. Aspects such as heating, lighting and ventilation systems have been appraised and technical changes made to ensure that systems are running as efficiently as possible and operating only at times of occupancy. Current savings have been made in electricity and gas through these technical changes, delivering an annual carbon saving of 118 tonnes.

The Health Board continues to work towards introducing more sustainable and resource efficient methods of processing waste generated from health care activities. The Health Board is working towards a zero-waste to landfill approach (currently at approximately 3% landfill waste), in collaboration with external contractors. The vast majority of non-recyclable general waste now goes to energy-from-waste plants to generate sustainable electricity.

In April 2024 new legislation came into effect in Wales meaning that non-domestic premises have to segregate recycling into separate waste streams for collection. This law implements a number of actions to increase the quality and quantity of recycling which are included in the Welsh Government's Circular Economy Strategy for Wales. The main aim of the legislation is to address the levels of recycling rates in non-domestic properties thereby; turning waste into a resource, improving the quality of recyclable materials recovered and realising associated carbon reductions.
There is an extension for healthcare premises with in-patients until April 2026 for Health Boards to adequately prepare, but all non-inpatient sites are already included.

We will realise the carbon benefits of this initiative going forward, to be included in next year's report.

Another key element of the legislation is the segregation and separate collection of food waste. The Health Board is now compliant at all sites with patient dining and/or a catering retail function. This waste, which previously was disposed of to foul sewer or as general waste is now processed in an anaerobic digestion plant creating energy as a by-product.

The Health Board continues to operate a third party certified Environmental Management System (EMS) to the international standard ISO 14001:2015. The EMS has been developed to become the focal point for driving forward continual environmental and sustainability improvements. It provides a joined-up approach for the management of waste minimisation initiatives, recycling, energy and carbon management, sustainable procurement, and sustainable travel initiatives. The Health Board places high importance on continued certification to ISO14001:2015 and the assurance it provides to the Board and our stakeholders.

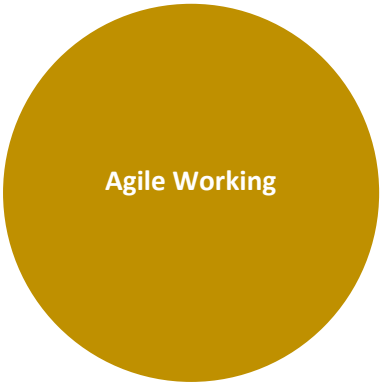
The Health Board complies with Biodiversity and Resilience of Ecosystems Duty under Section 6 of the Environment (Wales) Act 2016, which seeks to enhance resilience and biodiversity across the estate. To this end, several local initiatives are in place including wildflower planting in conjunction with external art installations at the Grange University Hospital, the continued success and development of the Walled Garden at Llanfrechfa Grange by the charitable organisation 'Friends of Llanfrechfa Grange Walled Garden.' There was also a successful funding bid for a community orchard at Trethomas Health Centre which is now complete.

Biodiversity Enhancement Reports have been completed at St Cadocs Hospital, Serennu Childrens Centre, Nevill Hall Hospital, Ysbyty Ystrad Fawr and Maindiff Court Hospital after securing funding from the Health & Social Care Climate Emergency National Programme in 2022/23. These enhancement reports will be used to inform any future biodiversity work the health board can deliver, where appropriate funding opportunities permit.

The Health Board proactively planned to remove the majority of Nitrous Oxide use from it sites, manifolds have been decommissioned in all eLGH sites and an audit is underway to understand the N2O usage in the Grange University Hospital and whether the manifold can also be decommissioned and replaced with portable cylinders.
Early indicators from a BOC Ltd report, a significant reduction in the health board's use of nitrous oxide. Data will be provided in next year's report.

There is work underway on reducing the waste of non-sterile gloves. The use of these gloves more than doubled during the pandemic and there is a need to return the usage to pre-pandemic figures. Current CO2 emissions for gloves are 571, 235, 600 grammes.

The UK Climate Change Act 2008 provides a legal framework to cut UK greenhouse gas emissions and build the UK's ability to adapt to a changing climate. Responsibility for climate change adaptation is devolved, meaning national governments in Northern Ireland, Wales and Scotland are responsible for developing their own respective adaptation programmes and plans.



We understand the importance of agile and flexible working to staff wellbeing through giving greater autonomy of work and improving work life balance. This year we have strengthened our Agile Working Strategy and Vision and will continue to build on areas of good practice. Set out in the vision were a number of principles which give a clearer steer and direction to people, a workplan of SMART objectives aligned to the Estate Strategy and Informatics Strategy and a dashboard with measurable benefits of Agile/Hybrid working. Through our resetting our agile vision we have reviewed our guidance and toolkits which incorporated staff welfare facilities to ensure they meet minimum standards. We have engaged with our services across most of our estates, undertaken agile assessments and explored agile working options in line with our Estate Strategy and Decarbonisation Strategy and we will continue programme of work this through 2024/5.

6. Integrated Medium Term Plan 2023/24 – Quality and Safety

In April 2023, the Health Board launched its first Quality Strategy and Patient Experience & Involvement Strategy. As part of ensuring successful implementation a Quality Outcomes Framework (QOF) was approved by the Patient, Quality, and Safety Operating Committee (PQSOC) in Quarter One. It was acknowledged this would become an iterative framework that was under constant development throughout year one. The reporting of the QOF recognises the development of some of the measures as new ways of reporting and capturing what is important for patients and the population and for the Board are brought in line. This process will continue to be refined by working with planning and the digital, data and technology team.

The Health and Care Quality Standards provide a clear framework to help plan, deliver and monitor healthcare services in Aneurin Bevan University Health Board. The Quality Outcomes Framework (QOF) is mapped to ensure the organisation develops and delivers our services around the six domains of quality and the six quality enablers. These outcomes and indicators collaboratively establish a set of quality indicators that align with the Health Boards priorities and strategic goals. The indicators cover all aspects of care, clinical outcomes, patient safety, patient experience, and efficiency.



These 'pillars of quality' run through the organisation, ensuring that it delivers the highest standards of care under these domains. Providing data in these Pillars of Quality will enable the organisation to review our performance. The pillars are Quality Markers in the quality management system. Strengthening the quality management system helps us make sure decision-making focuses on improving the quality of health services.

In summary, during Quarter 3 the Health Board delivered:

- ✓ Review of the Serious Incident Policy
- ✓ Introduction of PALS
- ✓ Increase in early resolution of complaints
- ✓ Maintained RAMI and Crude Mortality Scores
- ✓ Improved provision of Safeguarding training
- ✓ Improved cancer programme outcomes through adoption of Quality Improvement methodology.

(to be updated for Q4 if available)

The full QOF report for Quarter Three is available on the following link (to be added).

7. Well-Being of Future Generations

The Wellbeing of Future Generations (Wales) Act (2015) ('the Act') has the central aim of improving the social, economic, environmental and cultural wellbeing of Wales, whilst also reducing health inequalities through long term prevention and the delivery of sustainable, outcome focused services. The Act has seven wellbeing goals and five ways of working which help organisations understand how they can work more sustainably together to meet the duties of the Act.

The seven wellbeing goals



The five ways of working



Source: Future Generations Commissioner for Wales

During 2023/24, Aneurin Bevan University Health Board has worked closely with partners in Gwent Public Services Board to turn the findings of the Gwent well-being assessment into a well-being plan which will improve the social, economic, environmental and cultural wellbeing of citizens in Gwent. Using the five ways of working, Public Services Board partners have worked together to develop a plan which will deliver ambitious and transformational change that cannot be achieved by individual organisations alone. The plan will cover the five-year period 2023-28, and is based on two strategic objectives and five steps. These are:

Gwent Well-being Plan strategic objectives:

1. We want to create a fairer, more equitable and inclusive Gwent for all.
2. We want a climate-ready Gwent, where our environment is valued and protected, benefitting our well-being now and for future generations.

Gwent Well-being Plan steps:

1. Take action to reduce the cost-of-living crisis in the longer term.
2. Provide and enable the supply of good quality, affordable, appropriate homes.
3. Taking action to reduce our carbon emissions, help Gwent adapt to climate change, and protect and restore our natural environment.
4. Take action to address inequities, particularly in relation to health, through the framework of the Marmot Principles.
5. Enable and support people, neighbourhoods, and communities to be resilient, connected, thriving and safe.

Alongside the Gwent well-being plan, Aneurin Bevan University Health Board has led Gwent-wide partnership action to address inequity and the wider determinants of health as part of 'Building a Fairer Gwent'. Based on the eight Marmot principles, this work has resulted in a comprehensive set of recommendations for Gwent over the next five years which are currently being taken forward as part of implementation of the Gwent well-being plan. Further information about 'Building a Fairer Gwent', including a copy of the final report can be found at:
https://www.gwentpsb.org/en/gwent-marmot-region/

The Marmot principles

1. Give every child the best start in life. 2. Enable all children, young people and adults to maximise their capabilities and have control over their lives. 3. Create fair employment and good work for all. 4. Ensure healthy standard of living for all.	5. Create and develop healthy and sustainable places and communities. 6. Strengthen the role and impact of ill health prevention. 7. Tackle discrimination, racism and their outcomes. 8. Pursue environmental sustainability and health equity together.

Source: Institute of Health Equity

Aneurin Bevan University Health Board Wellbeing Objectives

During 2023/24 Aneurin Bevan University Health Board has continued to maintain a life course approach to its wellbeing objectives as it continues to endeavour to reduce health inequalities and improve population health. Unlike a disease-oriented approach, which focuses on interventions for a single condition often at a single life stage, the life course approach considers the critical stages, transitions, and settings where large differences can be made in promoting or restoring health and wellbeing of both current and future generations. Adopting the life course approach means identifying opportunities for minimising risk factors and enhancing protective factors through evidence-based interventions at important life stages, from the perinatal period through early childhood to adolescence, working age, pre-conception and the family-building

years, and into older age. It also capitalises on the potential to deliver an intergenerational approach to health improvement and reduce health inequalities from generation to generation and improve conditions of daily life. Our health services are there to provide universal coverage to everyone throughout the life course, whilst also recognising that we need to provide more support to those in greatest need.



Source: Aneurin Bevan University Health Board IMTP 2023-26

This approach requires holistic, long-term, policy and investment strategies and engagement that promote better health outcomes for individuals and greater health equity in the population. Aneurin Bevan University Health Board is confident this approach can achieve high returns for health and sustainable development, both by limiting ill health and the accumulation of risk throughout life and by contributing to social and economic development.

The five ways of working set out in the Act have continued to be demonstrated by Aneurin Bevan University Health Board in 2023/24. Through the regional partnership arrangements of the Regional Partnership Board and Public Services Board, **integration** has been demonstrated through joint approaches to wellbeing, health and social care delivery. Aneurin Bevan University Health Board's communications team have undertaken a number of public **involvement** and engagement activities during 2023/24. Through work on the Well-being Plan and Area Plan, Aneurin Bevan University Health Board has worked in partnership to establish a **long-term** vision for wellbeing in Gwent. Through 'Building a Fairer Gwent', Aneurin Bevan University Health Board has worked in partnership to deliver an approach to **prevention** embedded in the social

determinants of health. Finally, the work of both Gwent Regional Partnership Board and Gwent Public Services Board demonstrate how Aneurin Bevan University Health Board is working in **collaboration** to achieve gains for the population of Gwent that cannot be delivered by individual organisations alone.

For further information, please visit:
Gwent Regional Partnership Board https://gwentrpb.wales/
Gwent Public Services Board http://www.gwentpsb.org/en/

9. Equality, Diversity and Inclusion

The Health Board has developed and published an Annual Equality Report 2023/24, in line with the Public Sector Equality Duty 2011, which summarises how the Board has performed in meeting its legal duties as set out in the Equality Act (2010) and the Human Rights Act (1998). The report details the work the organisation has undertaken to further advance equality.

During the reporting period of 2023/24 the following improvements were made:

- A snapshot of our Equality data sets as of 31 March 2023, has shown that there is some improvement in our equality statistics (e.g., non-disclosure of sexual orientation via ESR is down by 3% since 2022; non-disclosure of disability via ESR is down by 4% since 2022; and our median gender pay gap has reduced to 16.20% from 18.72% in 2022).
- We have developed a framework around our Staff Diversity Network to ensure a mechanism for their voice. This has included the introduction of Executive Sponsors, nominations of Network Chairs, development of Terms of Reference, and approved protected time for Network members. This work will continue into 2024/25 to ensure that our Networks grow in maturity and to contribute positively and proactively to the EDI agenda.
- Development of an organisational level Anti-Racism Action Plan to meet our obligations under Welsh Government's Anti-Racist Wales Action Plan.
- The pre-consultation engagement and public consultation on our reviewed Strategic Equality Plan (SEP) for 2024-2028 has resulted in increased engagement and trust with both staff, community members and stakeholders, upon which we intend to build in the coming four years to ensure co-production and co-design are at the heart of everything that we do.
- Following the successful pilot of the SignLive service, which provides communication support for Deaf patients, their families and those that use British Sign Language, this service will be available across the Health Board.

The report highlights the Health Board's continued committed to proactively meeting the diverse needs of the communities who use our services and those we employ.

Equality, Diversity and Inclusion (EDI) and Human Rights are a golden thread of all activities and remain a key executive and board priority of the Health Board. We recognise the ongoing nature of this work and will continue to monitor and measure our outcomes.

10. Welsh Language Regulations

The Health Board works collaboratively with Welsh Government, the Welsh Language Commissioners office and our partners across NHS Wales and continues to make good progress in our work in relation to Welsh language service delivery. As we strive to deliver the best care to all those we service we recognise that the ability to communicate with our Welsh speaking service users in Welsh is key to this.

The Health Boards Welsh Language Annual Report 2022/23 addresses the statutory duty of Aneurin Bevan University Health Board to provide an annual account to the Welsh Language Commissioner on compliance with its Welsh Language Standards under the Welsh Language (Wales) Measure 2011. The report has been prepared in accordance with Welsh Language Standard 120. The report shows our progress and work in this field. It notes key achievements as well as our strategy and plans for the future.

The Annual Report for 2022/23 is available on-line in both Welsh and English
https://abuhb.nhs.wales/files/key-documents/other-reports/welsh-language-report-2022-2023-pdf/ English

https://bipab.gig.cymru/ffeiliau/key-documents/adroddiad-blynyddol-fersiwn-cymraeg-2022-23-pdf/ Welsh

The report for 2023-2024 will be published in September 2023.

11. Financial Management and Performance

The Annual Accounts 2023/24, at Section 3 of the Annual Report and Accounts 2023/24, Page XX, sets out the detailed accounts for the full year to 31 March 2024 for Aneurin Bevan University Health Board. These accounts are prepared under International Financial Reporting Standards (IFRS).

The Health Board has two statutory financial duties:

- To breakeven over a rolling three-year period; and
- To submit an Integrated Medium-Term Plan (IMTP) to secure compliance with breakeven over three years.

Revenue Resource Performance

Aneurin Bevan University Health Board has not met its financial duty to break-even against its Revenue Resource Limit over the 3 years 2021-22 to 2023-24 period, the Board reported an overspend of £49,754K as shown below:

3 Year Revenue Breakeven Duty	2021/22	2022/23	2023/24	Total
	£000	£000	£000	£000
Underspend Against Allocation	249	- 36,842	- 49,754	- 86,347

Capital Resource Performance

In addition to a revenue resource limit the Health Board has a capital resource limit (CRL) that sets the target for capital expenditure. The target of £56.742M was met in 2023/2 with a small underspend of £41K. The target is measured over a 3 year period as shown below:

3 Year Capital Resource Duty	2021/22 £000	2022/23 £000	2023/24 £000	Total £000
Underspend Against Allocation	50	43	41	134

Long Term Expenditure Trend

3. Analysis of gross operating costs

3.1 Expenditure on Primary Healthcare Services	2019-20	2020-21	2021-22	2022-23	2023-24
General Medical Services	103,343	108,993	112,524	116,217	122,671
Pharmaceutical Services	22,900	27,109	25,082	25,273	25,756
General Dental Services	36,608	33,079	38,030	39,817	39,870
General Ophthalmic Services	8,911	8,734	9,343	8,866	10,659
Other Primary Health Care expenditure	2,872	2,289	2,487	2,612	4,373
Prescribed drugs and appliances	102,280	106,852	106,282	114,331	121,947
Total	276,914	276,914	287,056	307,116	325,276

	£'000	£'000	£'000	£'000	£'000
3.2 Expenditure on healthcare from other providers	2019-20	2020-21	2021-22	2022-23	2023-24
Goods and Services from Other NHS bodies	103,179	103,278	117,637	117,587	129,254
Goods and services from WHSSC / EASC	144,458	161,384	177,035	198,320	208,640
Continuing Care	71,005	81,347	83,675	86,006	99,136
Other	61,107	71,795	85,054	72,240	71,368
Total	379,749	417,804	463,401	474,153	508,398

3.3 Expenditure on Hospital and Community Health Services

	£'000	£'000	£'000	£'000	£'000
	2019-20	2020-21	2021-22	2022-23	2023-24
Staff Costs	579,760	671,972	714,255	762,081	788,703
Non Pay	152,277	172,611	191,827	200,118	238,743
Depreciation and Impairments	23,197	96,361	31,056	30,804	59,994
Losses, special payments and irrecoverable debts	3,154	1,886	2,831	1,526	3,217
Other operating expenses	7,990	8,526	11,009	9,538	14,599
Total	766,378	951,356	950,978	1,004,067	1,105,256

Long Term Revenue Performance Trend

2. Financial Duties Performance

2.1 Revenue Resource Performance

Annual financial performance

	2019-20	2020-21	2021-22	2022-23	2023/24	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Net operating costs for the year	1,319,803	1,551,819	1,598,803	1,676,282	1,818,456	5,093,541
Less general ophthalmic services expenditure and other non-cash limited expenditure	(161)	(1,423)	(58)	148	599	689
Less revenue consequences of bringing PFI schemes onto SoFP	0	0	0	0	0	0
Less unfunded revenue consequences of bringing PFI schemes onto SoFP	0	0	0	0	29	29
Total operating expenses	1,319,642	1,550,396	1,598,745	1,676,430	1,819,084	5,094,259
Revenue Resource Allocation	1,319,674	1,550,641	1,598,994	1,639,588	1,769,330	5,007,912
Under /(over) spend against Allocation	32	245	249	(36,842)	(49,754)	(86,347)

Aneurin Bevan University LHB has not met its financial duty to break-even against its Revenue Resource Limit over the 3 years 2021-22 to 2023-24.

The Health Board will, in dialogue with Welsh Government, confirm the implications for reporting this deficit as part of the 2024/25 IMTP.

The health board received £49.9m of strategic cash support in 2023/24.

2.2 Capital Resource Performance

	2019-20	2020-21	2020-21	2022-23	2023/24	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Gross capital expenditure	133,286	112,376	52,167	41,011	62,681	155,859
Add: Losses on disposal of donated assets	7	0	0	2	1	3
Less NBV of property, plant and equipment and intangible assets disposed	(555)	(884)	(3,115)	(61)	(5,845)	(9,021)
Less capital grants received	(93)	(333)	(22)	(62)	0	(84)
Less donations received	(300)	(201)	(166)	(210)	(136)	(512)
Charge against Capital Resource Allocation	132,345	110,958	48,864	40,680	56,701	146,245
Capital Resource Allocation	132,373	110,971	48,914	40,723	56,742	146,379
(Over) / Underspend against Capital Resource Allocation	28	13	50	43	41	134

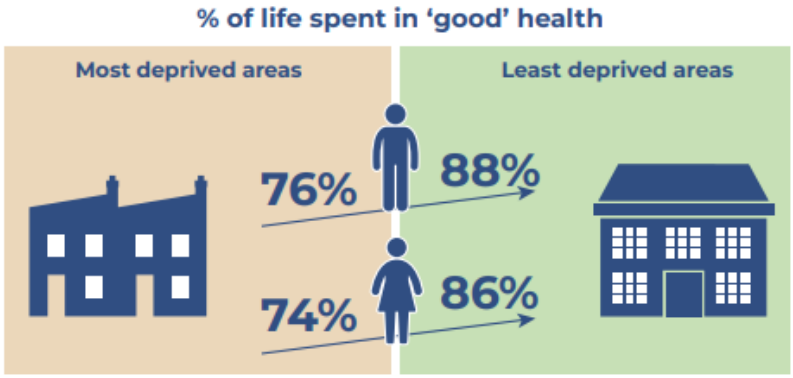
Aneurin Bevan University LHB has met its financial duty to break-even against its Capital Resource Limit over the 3 years 2021-22 to 2023-24.

The Health Board's financial statements have been prepared in accordance with the 2023/24 NHS Wales Manual for Accounts. The accounting policies contained in that manual follow the 2022-23 Financial Reporting Manual (FReM) in accordance with international accounting standards in conformity with the requirements of the Companies Act 2006, to the extent that they are meaningful and appropriate to the NHS in Wales.

The Manual for Accounts makes clear that accounts should be prepared on a going concern basis where there is the anticipated continuation of service in the future. The assumption has been made that the services of Aneurin Bevan University Health Board will continue in operation. Consequently the going concern basis has been adopted.

12. Conclusion and Forward Look

The mission for the Health Board is to improve population health, and through doing this, reduce the health inequalities experienced by our communities. The current gap, 13 years (men) and 20 years (women), in healthy life expectancy between our wealthiest and poorest communities is significant. Our plan for 2023/24 and going forward articulates the steps we are taking to deliver a Healthier Wales and The Well-being of Future Generations (Wales) Act 2015.



Since November we have been working on the development of a new long-term strategy that articulates joint commitments with our population through to 2035. This will help shape our model of sustainability going forward. We are not waiting for our strategy to take action where we have evidence of quality concerns, workforce challenges and aging estate. Our plan for 2024/25 sets out the significant service redesign we will undertake to rightsize our service capacity aligned with patient need.

We are committed to continue our improvement on how the system is performing, whilst many people receive great care, we know there is more to do to improve our system. 23,232 people were waiting over the target time of 52 weeks for planned appointments and treatments at the start of 2024, behind each of these numbers is an individual story. Whilst improvements have been made in our emergency care system, waiting times for ambulances are too long and subsequently, we are not meeting the 4 hours target for the majority of patients to be seen, triaged, treated, and discharged in urgent and emergency care - we only meet this 75% of the time. People are also spending too long in our hospitals. There are regularly around 200 people who have completed the medical element of their care waiting to be discharged for a range of reasons related to wider support or care, many of whom are waiting over 3 weeks. We also frequently hear stories of the challenge of getting an appointment with a GP and support in the community and whilst there is much being done to improve this situation, we know there is still much more to do.

It is the ambition for improvement that drives the organisation forward in making improvements for the population

Part 2:
Accountability Report

1st April 2023 –
31st March 2024

INTRODUCTION TO THE ACCOUNTABILITY REPORT

Aneurin Bevan University Health Board is required to publish, as part of our annual reporting, an Accountability Report. The purpose of the Accountability Report section of the Annual Report has been designed to demonstrate the ways in which the Health Board is meeting its key accountability and reporting requirements.

This Accountability Report has three sections:

1. Corporate Governance Report

This explains the composition of the Health Board, its governance structures and arrangements and how the Health Board seeks to achieve its objectives and responsibilities to meet the needs of the people we serve. The Corporate Governance Report includes:

A. The Directors' Report
B. The Statement of the Chief Executive as the Accountable Officer and the Statement of Directors' Responsibilities in respect of the Accounts
C. The Annual Governance Statement.

2. Remuneration and Staff Report

This section contains information about the staff of the organisation, particularly focusing on the remuneration of its Board and senior management, fair pay ratios and other staff information, such as sickness absence rates.

3. Senedd Cymru/Welsh Parliament Accountability and Audit Report

This section contains a range of disclosures on the regularity of expenditure, fees, charges, compliance with cost allocation, material remote contingent liabilities, long-term expenditure trends and charging requirements set out in HM Treasury guidance.

Corporate Governance Report 2023/24

Including:

- **A: The Directors' Report**
- **B (1): The Statement of the Chief Executive as the Accountable Officer**
- **B (2): The Statement of Directors' Responsibilities in respect of the Accounts**
- **C: The Annual Governance Statement**

A: THE DIRECTORS' REPORT

Aneurin Bevan University Local Health Board is a statutory body that was established on 1st June 2009 and became operational on the 1 October 2009 under *The Local Health Boards (Establishment and Dissolution) (Wales) Order 2009 (S.I. 2009/778), "the Establishment Order".*

The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779) ("The Constitution Regulations") set out the constitution and membership arrangements of Local Health Boards, the appointment and eligibility requirements of members, the term of office of non-officer members and associate members. In line with these Regulations the Board of Aneurin Bevan University Health Board comprises:

- a chair;
- a vice-chair;
- officer members; and
- non-officer members.

The members of the Board are collectively known as "the Board" or "Board members"; the officer and non-officer members (which includes the Chair) are referred to as Executive Directors and Independent Members respectively. All members have full voting rights.

In addition, Welsh Ministers may appoint up to three associate members. Associate members have no voting rights.

Before an individual may be appointed as a member or associate member they must meet the relevant eligibility requirements, set out in *The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779) ("The Constitution Regulations")*, and continue to fulfil the relevant requirements throughout the time that they hold office. The Regulations can be accessed via the Government's legislation website:
http://www.legislation.gov.uk/wsi/2009/779/contents/made

Further detail on the Board's membership and composition during 2023/24 is available within Section C: The Annual Governance Statement.

Board Members' Interests

Details of company directorships and other significant interests held by members of the Board which may conflict with their responsibilities are maintained and updated on a regular basis.

The document, which can be accessed in the link below, shows details of directorships of other organisations or other interests that have been declared by the members of the Board of Aneurin Bevan University Health Board, and staff across the organisation, in line with the Standards of Business Conduct Policy, as at the 31st March 2024. This information is

available on the Health Board's Internet site and can be accessed by following this link.

Personal Data Related Incidents

Information on personal data related incidents formally reported to the Information Commissioner's Office and "serious untoward incidents" involving data loss or confidentiality breaches are detailed on page xx of the Annual Governance Statement at Section C.

Environmental, Social and Community Issues

The Board is aware of the potential impact that the operation of the Health Board has on the environment and it is committed to wherever possible:

- Ensuring compliance with all relevant legislation and Welsh Government Directives;
- Working in a manner that protects the environment for future generations by ensuring that long term and short-term environmental issues are considered; and
- Preventing pollution and reducing potential environmental impact.

The Health Board complies with Biodiversity and Resilience of Ecosystems Duty under Section 6 of the Environment (Wales) Act 2016, which seeks to enhance resilience and biodiversity across the Health Board's estate.

The Board's Annual Report for 2023/24 and Integrated Medium Term-Plan (IMTP) 2022-25 (approved March 2022) sets out the Board's strategic priorities which have been set within the context (environmental, social and community issues) in which the Health Board is operating within.

The Performance Report (Part A) of the Annual Report and Accounts 2023/24 provides greater detail in relation to the achievements of the Health Board in delivering the IMTP during 2023/24.

Statement for Public Sector Information Holders

In-line with the disclosure requirements set out by the Welsh Government and HM Treasury, the Health Board confirms that it has complied with the cost allocation and charging requirements set out in HM Treasury guidance during the 2023/24 year.

B(1): STATEMENT OF THE CHIEF EXECUTIVE AS THE ACCOUNTABLE OFFICER OF ANEURIN BEVAN UNIVERSITY HEALTH BOARD

The Welsh Ministers have directed that the Chief Executive should be the Accountable Officer for Aneurin Bevan University Local Health Board. The relevant responsibilities of Accountable Officers, including their responsibility for the propriety and regularity of the public finances for which they are answerable, and for the keeping of proper records, are set out in the Accountable Officer's Memorandum issued by the Welsh Government.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as Accountable Officer.

As Accountable Officer, I confirm that, as far as I am aware, there is no relevant audit information of which the Health Board's Auditors are unaware, and I have taken all the steps that ought to have been taken to make myself aware of any relevant audit information and that the Health Board's auditors are aware of that information.

As Accountable Officer, I confirm that the Annual Report and Accounts 2023/24 as a whole is fair, balanced and understandable. I take personal responsibility for the Annual Report and Accounts and the judgements required for determining it as fair, balanced and understandable.

As Accountable Officer, I am responsible for authorising the issue of the financial statements on the date they are certified by the Auditor General for Wales.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as Accountable Officer.

_____

Name: Nicola Prygodzicz, Chief Executive **Date:**

SECTION B(2): STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS FOR 2023/24

The directors are required under the National Health Service Act (Wales) 2006 to prepare accounts for each financial year. The Welsh Ministers, with the approval of the Treasury, direct that these accounts give a true and fair view of the state of affairs of the Aneurin Bevan University Health Board and of the income and expenditure of the Health Board for that period.

In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting principles laid down by the Welsh Ministers with the approval of the Treasury
- make judgements and estimates which are responsible and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the account.

The directors confirm that they have complied with the above requirements in preparing the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the authority and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction by the Welsh Ministers.

By Order of the Board

Signed:

Ann Lloyd, Chair
Dated:

Nicola Prygodzicz, Chief Executive
Dated:

Robert Holcombe, Director of Finance and Procurement
Dated:

C: ANNUAL GOVERNANCE STATEMENT 2023/24

SCOPE OF RESPONSIBILITY

The Board is accountable for Governance, Risk Management and Internal Control. As Chief Executive of the Board, I have responsibility for maintaining appropriate governance structures and procedures as well as a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, whilst safeguarding the public funds and the organisation's assets for which I am personally responsible. These are carried out in accordance with the responsibilities assigned by the Accountable Officer of NHS Wales.

The annual report outlines the different ways the organisation has had to work both internally and with partners in response to the unprecedented pressure in planning and providing services. It explains arrangements for ensuring standards of governance are maintained, risks are identified and mitigated and assurance has been sought and provided. Where necessary additional information is provided in the Governance Statement, however the intention has been to reduce duplication where possible. It is therefore necessary to review other sections in the Annual Report alongside this Governance Statement.

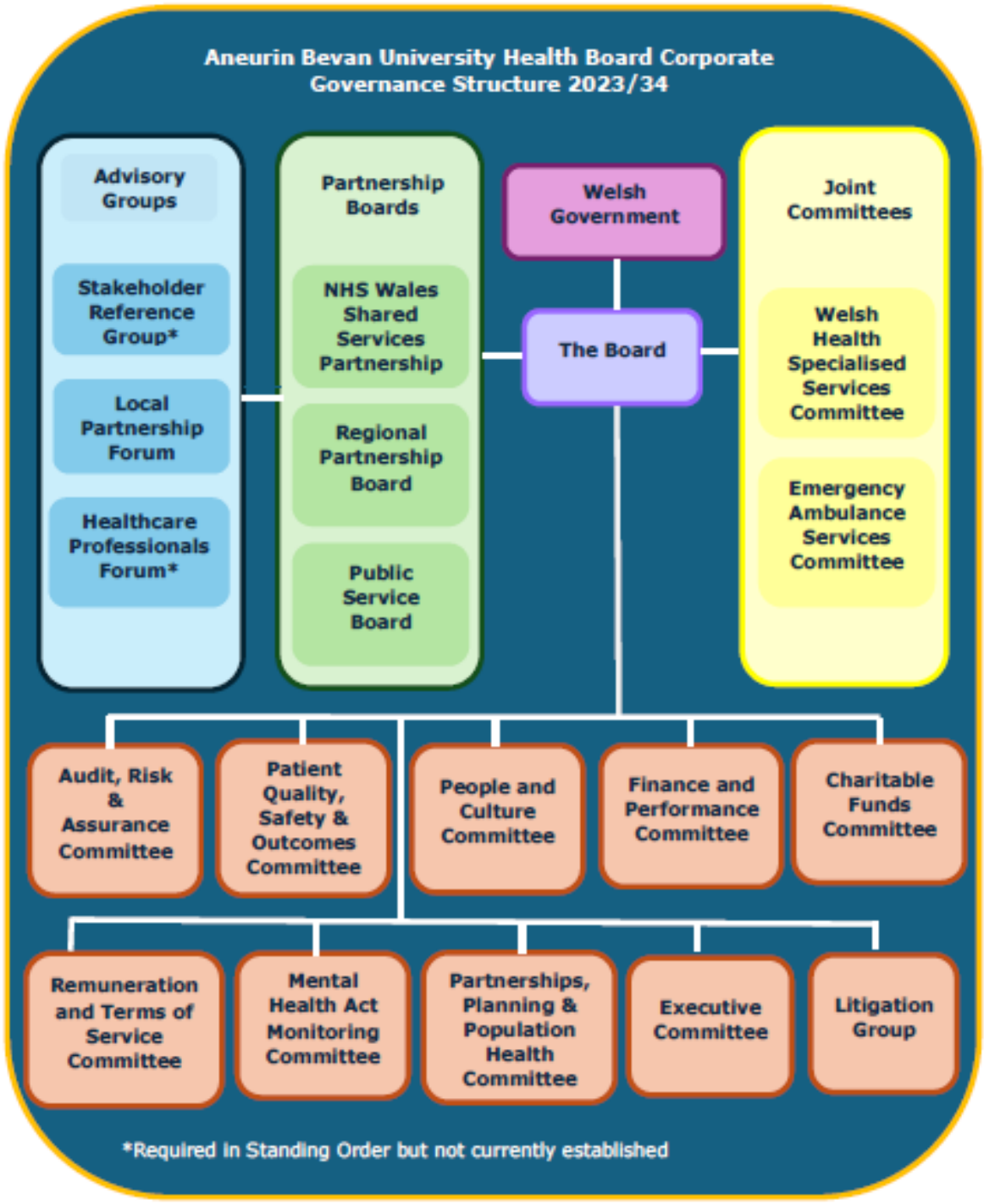
Welsh Government's Escalation and Intervention Arrangements for NHS Wales sets out the collective arrangements in place between the Welsh Government and external review bodies for identifying and responding to serious issues affecting NHS service delivery, quality and safety of care, and organisational effectiveness. As at 31st March 2024, Aneurin Bevan University Health Board was in 'Targeted Intervention' for planning and finance and 'Enhanced Monitoring' for performance and outcomes related to urgent and emergency care pathways resulting in extended waits for patients in ambulances and emergency department clinical assessment at the Grange University Hospital. The Performance Report (Part 1) of the Annual Report and Accounts for 2023/24 provides greater detail on the Health Board's performance and improvement actions in these areas.

OUR GOVERNANCE AND ASSURANCE FRAMEWORK

Aneurin Bevan University Health Board has agreed Standing Orders for the regulation of proceedings and business of the organisation. These are designed to translate the statutory requirements set out in the LHB (Constitution, Membership and Procedures) (Wales) Regulations 2009 into day to day operating practice, and together with the adoption of a scheme of matters reserved to the Board, a scheme of delegation to officers and others and Standing Financial Instructions, they provide the regulatory framework for the business conduct of the Health Board and define its 'ways of working'. These documents, together with the Board's Assurance Framework and a range of corporate policies set by the Health Board make

up the Governance and Assurance Framework and arrangements of the organisation.

The diagram below outlines the corporate governance structure in place during 2023/24:



Membership of the Health Board and its Committees

Attachment 1 provides the Board's membership during 2023/24 and attendance at Board and Committee meetings respectively for this period. The membership of the Board and changes during 2023/24, are outlined in Table 1 below:

Name	Designation	Dates (If not full year)
Executive Directors		
Nicola Prygodzicz	Chief Executive	
Hannah Evans	Director of Strategy, Planning and Partnerships	From 01/04/2023
Chris Dawson-Morris	Interim Director of Planning and Performance	Until 03/04/2023
Rob Holcombe	Director of Finance and Procurement	
Dr James Calvert	Medical Director / Deputy Chief Executive	
Sarah Simmonds	Director of Workforce and OD	
Jennifer Winslade	Director of Nursing	
Peter Carr	Director of Therapies and Health Sciences	
Tracy Daszkiewicz	Director of Public Health	
Dr Chris O'Connor	Interim Director of Primary, Community and Mental Health Services	Until 30/04/2023
Leanne Watkins	Director of Operations	Until 30/04/2023
Leanne Watkins	Chief Operating Officer	From 1/05/2023
Independent Members		
Ann Lloyd	Chair	
Pippa Britton	Vice Chair	From 3rd May (interim prior to this)
Shelley Bosson	Independent Member (Community)	
Louise Wright	Independent Member (Trade Union)	
Richard G Clarke	Independent Member (Local Authority)	
Professor Helen Sweetland	Independent Member (University)	
Paul Deneen	Independent Member (Community)	
Iwan Jones	Independent Member (Finance)	

Dafydd Vaughan	Independent Member (Digital)	
Martin Blakebrough*	Independent Member (Third Sector)	From 03/05/2023
Penny Jones	Independent Member (Community)	From 15/01/2024
Directors in Attendance**		
Paul Solloway	Director of Digital	From 28/06/2023
Special Advisors to the Board***		
Phil Robson	Special Advisor to the Board	
Associate Members******		
Vacant	Chair, Stakeholder Reference Group	
Vacant	Chair, Health Professionals Forum	
Vacant	Director of Social Services	
Director of Corporate Governance*******		
Rani Dash	Director of Corporate Governance	

***** Absent in agreement with Chair and Welsh Government (effective 01/09/24 to-date)

***The Director of Digital is not an Executive Post. The Director of Digital is therefore not a Board Member and attends meetings of the Board in an ex-officio capacity without voting rights.*

****The Board has discretion to appoint Special Advisors to support it in achieving its responsibilities. Special Advisors are not Board Members and therefore attend meetings of the Board in an ex-officio capacity without voting rights.*

*****Associate Members are Members of the Board but do not hold voting rights.*

****** Independent of the Board, the Director of Corporate Governance acts as the guardian of good governance within the Health Board. The Director of Corporate Governance is responsible for providing advice to the Board as a whole and to individual Board members on all aspects of governance.*

The Role of the Board

The Board, chaired by Ann Lloyd CBE, has been constituted to comply with the Local Health Board (Constitution, Membership and Procedures) (Wales) Regulations 2009. The Board functions as a corporate decision-making body, Executive Directors and Independent Members being full and equal members and sharing corporate responsibility for all the decisions of the Board.

The Board is made up of individuals from a range of backgrounds, disciplines and areas of expertise. The Board comprises the Chair, Vice Chair and nine other Independent Members and the Chief Executive and eight Executive Directors. There are also Associate Independent Member

positions, Special Advisors and other senior managers who routinely attend Board Meetings. The full membership of the Board and their lead roles and committee responsibilities are outlined in **Attachment 1**.

The Board sits at the top of the organisation's governance and assurance systems. Its principal role is to exercise effective leadership, provide strategic direction and control. The Board is accountable for governance and internal control in the organisation and the Chief Executive as Accountable Officer, is responsible for maintaining appropriate governance structures and procedures.

In summary, the Board:

- Sets the strategic direction of the organisation within the overall policies and priorities of the Welsh Government and the NHS in Wales;
- Establishes and maintains high standards of corporate governance;
- Ensures the delivery of the aims and objectives of the organisation through effective challenge and scrutiny of performance across all areas of responsibility;
- Monitors progress against the delivery of strategic and annual objectives; and
- Ensures effective financial stewardship by effective administration and economic use of resources.

The Health Board must agree Standing Orders for the regulation of proceedings and business which are designed to translate the statutory requirements set out in the LHB (Constitution, Membership and Procedures) (Wales) Regulations 2009 into day to day operating practice, and, together with the adoption of a scheme of matters reserved to the Board; a scheme of delegations to officers and others; and Standing Financial Instructions, they provide the regulatory framework for the business conduct of the Health Board and define - its 'ways of working'. These documents, together with the range of corporate policies set by the Board make up the Governance Framework.

Committees of the Board

Section 3 of Aneurin Bevan University Health Board's Standing Orders provides that "*The Board may and, where directed by Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance in the exercise of its functions*". In line with these requirements, the Health Board had in place a Committee Structure for 2023/24.

The committee structure has been designed to enable an appropriate balance between strategy, delivery and performance, and culture and takes into consideration feedback from Board Members and Audit Wales in respect of effectiveness.

During 2023/24, the following Committees were in place:

- Audit, Risk & Assurance Committee
- Patient Quality, Safety & Outcomes Committee
- People & Culture Committee
- Finance & Performance Committee
- Partnerships, Population Health and Planning Committee
- Mental Health Act Monitoring Committee
- Remuneration and Terms of Service Committee
- Charitable Funds Committee
- Litigation Group

The Terms of Reference and Operating Arrangements, meeting agendas and papers for each of these Committees can be found on the Health Board's website.

These Committees are Chaired by Independent Members of the Board. The Chair of each Committee reports regularly to the Board on the committee's activities. This contributes to the Board's assessment of risk, level of assurance and scrutiny against the delivery of objectives. In addition, and in-line with Standing Orders, each committee is required to produce an annual report.

In addition to the Board's formal meetings and formal Committee meetings, the following informal arrangements have been established to support the Board to fulfil its responsibilities:

- Board Development Sessions, held bi-monthly (6 times yearly), to focus on the development and effectiveness of the Board as a cohesive and unitary Board;
- Board Briefing Sessions, held bi-monthly (6 times yearly), to focus on key matters where informal discussion is required and to raise awareness of matters such as changes in policy or legislation; and
- Board Strategic Planning Sessions, held quarterly, to allow the Board informal development time to discuss collectively strategic developments and horizon planning.

Conducting Business with Openness and Transparency

In accordance with the Public Bodies (Admissions to Meetings) Act 1960 the Board and Committees are required to meet in public. Following the COVID-19 pandemic where the public health risk posed resulted in limitations on public gatherings, the Board and its Committees moved to meeting in a virtual setting meaning that it was not possible to allow the public to attend meetings of the Board and Committees.

Members of the public have been able to attend all Board meetings in person during 2023/24. In addition, the Microsoft Teams link is also published with the agenda and on social media channels to enable members of the public to observe the meeting in real time if they are unable to attend in person. All Board meetings in 2023/24 were recorded and published to the Health Board's You Tube Channel within 24 hours for public viewing.

During 2023/24, the Board's committees have continued to meet virtually and, due to capacity constraints, the Health Board has not been able to stream these in real-time for the public's viewing. Work is underway to address this in 2024/25 to ensure that the Health Board's business operates with full transparency and openness.

As the Health Board has not been able to allow the public to attend all meetings of its committees during 2023/24, the Health Board has not complied with its Standing Orders in this regard.

It is acknowledged that a hybrid approach to meetings will continue to be required in the future and the Health Board will work to ensure members of the public can attend meetings in person and/or virtually.

To ensure Board and Committee business was conducted in as open and transparent manner as possible the following actions were taken:

- All Board and Committee meeting agenda packs have been published to the Health Board's website in advance of meetings;
- Meetings of the Board have been recorded and published to the Health Board's You Tube Channel within 24 hours;
- The Health Board's Annual General Meeting in September 2023 was livestreamed, with in person attendance also permitted.

The Health Board and its Committees have sought to undertake a minimum of its business in private sessions and ensure business, wherever possible, is published into the public domain. The Committees that do not publish information publicly is either because of the confidential nature of their business, such as the Remuneration and Terms of Service (RATS) Committee, or they are informal developmental type meetings such as the Board Strategic Planning Sessions discussing plans and ideas often in their formative stages.

Meetings of the Board and its Committees are formally recorded with minutes considered for approval at the next available meeting, respectively. In addition, the Director of Corporate Governance maintains Decision Logs for all decisions taken by the Board and the Executive Team.

Items considered by the Board in 2023/24

During 2023-24, the Board held 6 scheduled meetings, as well as its Annual General Meeting on 27th September 2023.

All the meetings of the Board in 2023/24 were appropriately constituted and quorate. The key business and risk matters considered by the Board during 2023/24 are outlined below.

Further information can be obtained from the published Board meeting papers on the Health Board's website via the following link.

Business Cases:

- Approved the **Regional Cataract Business Case**, subject to funding from Welsh Government.
- Approved the **Same Day Emergency Care (SDEC) Business Case** for Ysbyty Ystrad Fawr.
- Endorsed the **Velindre Cancer Centre Business Case.**

Governance and Assurance

- Received assurance in respect of arrangements for compliance with the **Nurse Staffing Levels (Wales) Act.**
- Approved the **Annual Report and Accounts 2022-23.**
- Approved the **Charitable Funds Annual Accounts and Annual Report 2022-23**
- Received the following **Annual Reports**:
  - Trade Union Partnership Forum
  - Communications and Engagement
  - Health and Safety
- Received the **Audit Wales Annual Audit Report and Structured Assessment.**
- Approved a revised **Risk Management Framework.**

Routine Business

- Ratified actions taken by the Chair, on behalf of the Board, to seal documents affixing the Health Board's Common Seal.

Plans/Strategies/Policies/Service Change

- Endorsed the **Nursing, Midwifery and Specialised Community Public Health Nurses Workforce Strategy.**
- Approved an urgent service change to **consolidate Stroke Services** to a single Hyper Acute Stroke Unit (HASU) at the Grange University Hospital and a single rehabilitation ward within YYF initially, pending a more detailed plan.
- Received the evaluation against the implementation of the **Integrated Winter Resilience Plan 2022/23.**
- Endorsed the proposal for a **Proof of Concept and Service Evaluation for Enhanced Care at YYF**, to improve quality, safety and patient experience.
- Approved the **Nursing and Midwifery Strategy 2023-26**.
- Approved the **Quality and Safety Systems Framework for Speaking Up** and associated action plan.
- Approved the **Winter Plan 2023/24**.
- Approved consultation and engagement on the **Strategic Equality Plan.**
- Approved **Patient Incident Reporting and Management Policy**.
- Endorsed the **consolidation of services at St Woolos Hospital.**
- Noted the outcome of engagement for the **MIU provision across Gwent** and approved the implementation of the preferred option.
- Approved the draft opening **Capital Programme for 2024/25.**

- Considered and discussed the Health Board's financial performance and the related risks being managed by the organisation.
- Considered the Board's performance against key local and national targets and the actions being taken forward to improve performance.
- Received assurance reports from the Committees and Advisory Groups of the Board.
- Received update reports from the Executive Team in respect of key issues locally, regionally and within NHS Wales.
- Reviewed the Corporate Risk Register and sought assurance on the management of mitigating actions.

- Approved the **All Wales Individual Patient Funding Request Policy**
- Approved the **Annual Plan 2024/25** and the **Delegated Budgets for 2024/25.**
- Agreed to support the signing of the pledge to become a **Corporate Parent.**
- Approved the **Strategic Equality Report** and updated **Strategic Equality Plan**.
- Approved a revised **Major Incident Plan.**
- Received the **Director of Public Health Annual Report**
- Considered the **Cancer Services Annual Report**

Patient Experience and Public Engagement

In March 2023, the Board approved its Patient Experience & Involvement Strategy. The Strategy's goals and objectives are to improve services and their effectiveness and safety and to improve people's experiences. It encompasses the Health Board's intent to engage patients, families, carers, staff and the wider community, with a commitment to listen to feedback, learn and therefore improve healthcare across all of our services.

The Board has remained committed to hearing and learning from the experience of staff and patients. During 2023/24 the Board received patient/staff stories in respect of:

- **Alcohol Care Team** - how proactive work makes a real different to patients' lives.
- **Children's Rights Participation Forum** – heard about the experiences of those using the Health Board's services who had been diagnosed with, or were awaiting diagnosis for, neurodivergence.
- **Tyleri Ward Community Resource Team** (CRT)– Nurse led approach on Tyleri Ward and its functioning as a CRT Direct Admission Unit.
- **Psychological Recovery in Cancer Services –** improvements to the service following patient feedback.
- **Volunteer to Career –** turning volunteering opportunities into meaningful employment.

Throughout 2023/24, **Llais, Gwent Region** attended meetings of the Board to provide an overview of recent issues of concern and positive observations or public feedback being addressed by Llais in relation to the planning and delivery of health services in Gwent.

Items considered by Committees of the Board

During 2023/24, Board Committees considered and scrutinised a range of reports and issues, in line with the matters delegated to them by the Board. These included a range of internal and external audit reports and reports from other review and regulatory bodies, including Healthcare Inspectorate Wales.

As was the case in previous years, the Committees' consideration and analysis of such information has played a key role in the assessment of the effectiveness of internal controls, risk management arrangements and assurance mechanisms. The Committees also considered and advised on areas of local and national strategic developments and new policy areas.

An overview of the key areas considered by the Committees of the Board is provided below:

Audit, Finance and Risk Committee	Among the key issues considered by the Committee during 2023-24, as outlined in the Committee's Work Programme, the following were also considered: • Update Report on the Clinical Audit Plan • Update Report on Clinical Audit Activity • Audit Wales Orthopaedic Services in Wales: Tackling the Waiting List Backlog – National and Local Report • Audit Wales Primary Care Follow-Up Report • Audit Wales Stakeholder Perception Research Report • Compliance with Welsh Health Circulars (WHC) and Ministerial Directions • Implementation of the Governance Priorities set out within the IMTP 2022-25 • Adequacy of arrangements for declaring, registering and handling interests • Implementation of the Risk Management Strategy Realisation Plan • Counter Fraud, Bribery and Corruption Policy • Counter Fraud Annual Report, Workplan and activity reports The Committee reviewed and approved the audit strategies and plans from Audit Wales and Internal Auditors, NWSSP Audit & Assurance Services and received audit reports produced in support of them during 2023-24. In approving the strategies and plans, the Committee ensured that they were robust and linked to the health board's risk profile. During the year the Committee received Internal Audit reports in line with the agreed programme for 2023-24, including the management response from the relevant Executive Director.

	There were 29 individual reviews in the Internal Audit Plan 2023/24 and an additional review included regrading facilities. Subsequently, 3 audits were deferred leaving 27 in the plan. Of these, as at April 2024, 13 have been reported as final, 6 are in draft, 7 work in progress and one in the planning stage. (to be updated following May meeting)
Patient Quality, Safety and Outcomes Committee	Among the key issues considered by the Committee during 2023-24, as outlined in the Committee's Work Programme, the following were also considered: • Regular Committee Risk Reports detailing the key risks allocated to the Committee • Update in relation to the management of medical devices and equipment within the Health Board • Updates regarding progress made in the development of the business case to replace the Pharmacy Robot at the RGH • Quarterly reporting on the Performance of Patient Quality and Safety Outcomes, including: – Duty of Candour triggers – Infection Prevention and Control – COVID-19 Investigations – Falls – Health, Safety and Security – Complaints, Concerns and Compliments – HIW Inspections • Annual Reports: – Blood Management – Pharmacy and Medicines Management – Research and Development – Infection Prevention and Control – Safeguarding – Annual Clinical Audit Activity Report • National Incident Reporting Policy • Recommendations, relevant to the Committee from internal and external audit reports: – Health & Safety – Medical Equipment and Devices – Medicines Management – Monitoring Action Plan – Discharge Planning – Dementia Service – Structure Assessment – Putting Things Right: Advisory Review

Charitable Funds Committee	• Scrutinised applications for charitable funds • Reviewed charitable funds income and expenditure • Considered and endorsed the Charitable Funds Accounts and Annual Report 2022/23 • Received the Audit Wales – Audit of Accounts Report 2022/23
Mental Health Act Monitoring Committee	The role of the Mental Health Act Monitoring Committee (MHAMC) is to monitor and review the way in which the Health Board discharges its functions and responsibilities under the Mental Health Act 1983. The Committee therefore receives a quarterly report which provides assurance to the Committee on the compliance with the legislative requirements of the Mental Health Act. During the year the Committee also reviewed and agreed the revised Mental Health Act Managers Policy, strengthening arrangements for the recruitment and retention of Associate Hospital Managers. A **Power of Discharge Sub-Committee** has been established as a formal sub-committee of the MHAMC. The membership of this Committee is comprised of Associate Hospital Managers and provides advice and assurance that the processes associated with the discharge of patients from compulsory powers, used by the Sub Committee, are being performed correctly and in accordance with legal requirements. The Sub-Committee reports routinely to the Committee for assurance and developmental purposes.
People and Culture Committee	Among the key issues considered by the Committee during 2023-24, as outlined in the Committee's Work Programme, the following were also considered: • Key matters relating to Employee Relations and suspensions over 4 months. • Assurance regarding the retention of staff including progress against the action plan. • Delivery of the Welsh Government's Race Equality Action Plan for Wales and associated Health Board Implementation Plan. • Workforce Planning and Education Commissioning Numbers. Progress with the implementation of the People Plan 2022/25 • Results of Staff Wellbeing Surveys • Compliance with the Welsh Language (Wales) Measure 2011

Finance and Performance Committee	Amongst the key issues considered by the Committee during 2023-24 were the following: **Financial management and performance**: • Routine monitoring of the financial position of the Health Board through the provision of quarterly financial performance reports and specific focussed reports on efficiency and savings opportunities and delivery. • Focussed updates across a range of themes being considered by the Value and Sustainability Board, including Workforce, Non-Pay, Prevention, CHC, Medicines Management, Digital & Service Redesign. • Received the report for Value Based Healthcare in ABUHB, presenting the key service areas and patient groups benefitting from the use of patient related outcome measures. • Quarterly updates on Efficiency Opportunities. **Organisational performance and management:** Quarterly updates on organisational performance, with exception reporting in identified areas including Planned Care and Stroke. • Update reports relating to: – Radiology Informatics Systems Procurement (RISP) Programme, – IT systems, including the shortfall for funded and part funded digital schemes, and the associated risk with delays in national digital programmes. – Quality of Coding, including a proposed structure for delivery for the improvement of coding services, to enable the clinical coding services deliver a more modern and flexible service for the Health Board. – Outpatient Transformation Programme, describing a number of transformational schemes implemented, their impact, along with the programme plan for 2023/24. – Robotic Process Automation (RPA), – Discharge Programme and Delays, including an update on the progress and impact of the Integrated Discharge Hub, as part of the Six Goals Programme structure
Partnerships, Population Health and Planning Committee	Amongst the key issues considered by the Committee during 2023-24 were the following: • Quarterly updates on the work of the Public Service Board, including progress of the 'Building a Fairer Gwent, Gwent Marmot Programme' • Quarterly updates in respect of the business of the Regional Partnership Board, including work on the Area Plan and the development of the Partnership Capital Strategy and Plans • Discussed regional planning work undertaken throughout 2023/24, in regional Ophthalmology, Orthopaedics, Diagnostics services,

	Cancer services, Vascular services, Stroke services, Thoracic services and Hepato-Biliary and Pancreatic Surgery and the Welsh Sexual Assault Service • Updates on Major Capital programmes, strategic capital projects and estates rationalisation • Endorsed the approach to the development of the IMTP • Updates in relation to health Protection and endorsed the requirement for a permanent Health Protection Team • Update on Decarbonisation, including the Decarbonisation Action Plan 2023/24 and progress against the national programme to deliver the goal of net zero emissions by 2050 • Endorsed the Major Incident Plan for submission to Board • Quarterly updates on the delivery of the Health Boards Clinical Futures Programme, including: – Stroke Services – Homeward Bound Wards – General Internal Medicine – Minor Injury Units – Mental Health Services – Acute Frailty Response Team – Falls Pathway – Welsh Ambulance Service Team – Place Based Care – Primary Care Sustainability – Planned Recovery

Further information is available in the Annual Report for each Committee, published on the Health Board's website via the following link [ADD LINK once approved by Board in May]

Board Development and Briefing

Board members took part in a number of development and briefing sessions through 2023/24. Topics covered at these sessions included:

- Children's Rights Forum
- Annual Plan Priorities 2024/25 including Financial Outlook
- Urgent and Emergency Care
- IMTP 2024-27
- Financial Performance
- Staff Wellbeing and Employee Investigations
- Long Term Strategy
- Safeguarding Training
- Quality Strategy and Quality Assurance Framework
- Safey Flow Model
- Primary Care Sustainability
- Risk Management

Self Assessment and Evaluation

In line with Standing Orders, the Board is required to introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups.

The purpose of regular self-review is to promote self-knowledge, reflection and vigilance, and to develop and improve leadership and governance. It helps boards identify strengths and development areas to deliver continuous improvement. High performing boards are likely to carry out some form of self-review of their leadership and governance regularly.

In February 2023 the Board was asked to undertake individual assessment of its effectiveness during 2022/23, using the NHS England and NHS Improvement (NHSE and NHSI) Well-led Framework for Leadership and Governance Developmental Reviews. This was followed by a Development Session in June 2023 in which the Board identified areas for improvement during 2023/24. This session also took into consideration independent and objective feedback from auditors and inspectors, such as Audit Wales' Structured Assessment which comments on the existence of proper arrangements for the efficient, effective, and economical use of resources within the Health Board. The areas for improvement were presented to the Board in September 2023.

During 2023/24, Committees of the Board undertook a mid-year self-assessment. The findings from each of these self-assessments will be used to inform a comprehensive annual assessment of the Board's effectiveness for 2023/24. An overarching Board Business Improvement Plan will be developed, informed by the assessment of the Board and its Committees and other feedback such as Structured Assessment, for delivery in 2024/25.

ADVISORY GROUPS AND JOINT COMMITTEES

Advisory Groups

Aneurin Bevan University Health Board's Standing Orders require the Board to establish three advisory groups. These allow the Board to seek advice from and consult with staff and key stakeholders. They are the:

- Stakeholder Reference Group;
- Local Partnership Forum; and
- Healthcare Professionals' Forum.

Information in relation to the role and terms of reference of each Advisory Group can be found in the Health Board's Standing Orders on the Health Board's website.

Stakeholder Reference Group (SRG)

Aneurin Bevan University Health Board established its Stakeholder Reference Group (SRG) in 2010.

The SRG's role has been to provide independent advice on the Health Board's business, including: Early engagement and involvement in the determination of the Health Board's overall strategic direction; the provision of advice on specific service proposals prior to formal consultation; as well as feedback on the impact of the Health Board's operations on the communities it serves. The SRG should provide a forum to facilitate full engagement and active debate amongst stakeholders from across the communities served by the Health Board, with the aim of reaching and presenting a cohesive and balanced stakeholder perspective to inform the Health Board's decision making.

Since its establishment, the Health Board's engagement arrangements have evolved and continue to develop and mature. In particular, the COVID-19 pandemic required the Health Board to engage with our stakeholders and communities in new and different ways.

In view of these evolving engagement arrangements and given that the Stakeholder Reference Group last met in October 2021, a decision was taken to disband the SRG in its current form in October 2022, whilst the Health Board reviews and redesigns the role and constitution of the Group, ensuring it is fit for purpose and fully effective. A proposal for re-establishment of the SRG has been finalised and will be considered by the Board in 2024.

In the meantime, the Health Board continues to work alongside partners to engage and involve people who others are also seeking to engage. This enables strong partnership working, the sharing of resource and the ability to collaborate regarding joint solutions to challenges shared. Many organisations have been extremely generous in enabling our participation in their existing activities. The Health Board has previously attended:

- Local Authority Community Talk to Us Sessions, Warm Spaces and Cost of
- Living events;
- Housing Association Resident Complexes and events;
- Health & Wellbeing events and Freshers Fairs at Coleg Gwent Campuses; and
- School Parents evenings, coffee mornings and PTA events.

The Health Board is also represented at Gwent Citizens Panel, Torfaen Access Forum and works with third sector organisations, Gwent Association of Voluntary Organisations and Torfaen Voluntary Alliance.

The Health Board runs a comprehensive community engagement program that ensures communities can speak directly with Health Board staff and share their views on health services. In 2023/24, the Health Board spoke directly with over 6000 residents across 200 venues.

The Health Board is committed to working constructively in partnership with others to plan and secure the delivery of an equitable, high quality, whole system approach to health, well-being and social care for the population of Gwent. This is delivered in accordance with the Health Board's statutory duties and any specific requirements or directions made by the Welsh Ministers, which includes the development of population assessments and area plans.

Local Partnership Forum (Known as the Trade Union Partnership Forum [TUPF])

The TUPF is the formal mechanism for the Health Board and Trade Union/Professional Organisation Representatives to work together to improve health services. It is the forum where key stakeholders will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues. The TUPF is co-chaired by the Chair of Staff Representatives and the Chief Executive of the Health Board. Members are Staff Representatives (including the Independent Member for Trade Unions), the Executive Team and Chief Executive, the Director of Corporate Governance, the Assistant Directors of Workforce and OD and the Head of Workforce Governance. The Forum meets 6 times a year and the Board receives an Annual Report on the work of the Forum.

Healthcare Professionals' Forum (HPF)

The purpose of the HPF is to facilitate engagement and debate amongst the wide range of clinical interests within the Health Board's area of activity, with the aim of reaching and presenting a cohesive and balanced professional perspective to inform the Health Board's decision making.

In the latter part of 2023/24, the Board agreed the terms of reference for the establishment of the HPF known as the Clinical Advisory Group with the aim of holding the inaugural meeting in 2024/25. In the absence of this Group, the Board has continued to engage clinical professionals through its professional executive directors (Medical Director, Director of Nursing, Director of Therapies and Health Sciences and Director of Public Health) and existing professional management groups, such as the Clinical Directors Forum and System Leadership Group. The Board also engages with primary care providers through its cluster arrangements.

Joint Committees

As set out within the Health Board's Standing Orders, during 2023/24, the Board was required to establish the following joint Committees:

- The Welsh Health Specialised Services Committee (WHSSC) and
- The Emergency Ambulance Services Committee (EASC).

Welsh Health Specialised Services Committee (WHSSC)

The Welsh Health Specialised Services Committee (WHSSC) is responsible for the joint planning of Specialised and Tertiary Services on behalf of Local Health Boards in Wales.

WHSSC was established in 2010 by the Local Health Boards (LHBs) in Wales to ensure that the population of Wales has fair and equitable access to the full range of specialised services. In establishing WHSSC to work on their behalf, the seven LHBs recognised that the most efficient and effective way of planning these services was to work together to reduce duplication and ensure consistency.

WHSSC is hosted by Cwm Taf Morgannwg University Local Health Board. The Health Board is represented on the Committee by the Chief Executive and reports of the Joint Committee's activity are regularly reported to the Board.

Further detail in respect of Welsh Health Specialised Services Committee can be found on WHSSC's website

Emergency Ambulance Services Committee (EASC)

Emergency Ambulance Services in Wales are provided the Welsh Ambulance Services NHS Trust (WAST) and commissioning of Ambulance Services in Wales is a collaborative process underpinned by a quality and delivery framework. The framework provides for clear accountability for the provision of emergency ambulance services with the Chief Ambulance Services Commissioner (CASC) and the Emergency Ambulance Services Committee (EASC) acting on behalf of Health Boards and holding WAST to account as the provider of emergency ambulance services. EASC is hosted by Cwm Taf Morgannwg University Local Health Board. The Health Board is represented on the Committee by the Chief Executive and reports of the joint committee's activity are regularly reported to the Board.

Further detail in respect of Emergency Ambulance Services Committee can be found on EASC's website.

NHS Wales Joint Commissioning Committee

The National Health Service Joint Commissioning Committee (Wales) Directions 2024 (the Directions) came into force on 7th February 2024 which provide that the Local Health Boards in Wales will work jointly to exercise functions relating to the planning and securing of services specified within the Directions or as identified by the Local Health Boards. Specifically, these are: (a) specialised services for: (i) cancer and blood disorders, (ii) cardiac conditions, (iii) mental health and vulnerable groups, (iv) neurosciences, and (v) women and children; (b) services where there is agreement between the Local Health Boards that they should be arranged on a regional and national basis; (c) emergency medical services; (d) non-emergency patient transport services; (e) emergency medical retrieval and transfer services; (f) NHS 111 services; (g) sexual assault referral centres; and (h) other services as directed by the Welsh Ministers.

For the purpose of jointly exercising those functions set out within the Directions, the Local Health Boards will establish a joint committee to be operational on 1 April 2024, which will supersede the Welsh Health Specialised Services Committee and the Emergency Ambulance Services Committee as Joint Committees of Local Health Boards.

Statutory and Strategic Partnerships

Gwent Regional Partnership Board

The Gwent Regional Partnership Board (RPB) is established under Part 9 Social Services and (Wales) Wellbeing Act 2014 and the Partnership Arrangements (Wales) Regulations 2015, within which local authorities and local health boards are required to establish Regional Partnership Boards to manage and develop services to secure strategic planning and partnership working. RPBs also need to ensure effective services, and care and support is in place to best meet the needs of their respective population. The objectives of the Gwent Regional Partnership Board are to ensure the partnership bodies work effectively together to:

- Respond to the population assessment carried out in accordance with section 14 of the Act;
- Develop, publish and implement the Area Plans for each region covered as required under section 14A of the Act;
- Ensure the partnership bodies provide sufficient resources for the partnership arrangements, in accordance with their powers under section 167 of the Act; and
- Promote the establishment of pooled funds where appropriate.

Welsh Government has distributed a Health and Social Care Regional Integration Fund across Wales to the seven Regional Partnership Boards (RPBs) in Wales. The aim of the fund is to drive and enable integrated

working between social services, health, housing and the third sector and independent providers to develop sustainable services.

The Regional Integration Fund (RIF) is hosted by Aneurin Bevan University Health Board on behalf of the Gwent Regional Partnership Board and is a standing agenda item on the Regional Partnership monthly meetings. All matters in relation to the RIF are discussed and approved within the partnership forum. Information is cascaded throughout the partnership structures for transparency. Where needed, the RPB accommodates special meetings to sign off RIF investment plans where meetings schedules do not align with reporting or development timeframes.

Aneurin Bevan University Health Board Members included in the membership of the Regional Partnership Board are:

- Ann Lloyd, Health Board Chair
- Nicola Prygodzicz, Chief Executive
- Tracy Daszkiewicz, Director for Public Health & Strategic Partnerships
- Hannah Evans, Director of Strategy, Planning & Partnerships
- Phil Robson, Special Advisor to Health Board
- Pippa Britton, Vice Chair

Further detail in respect of the Gwent RPB can be found on the RPB's website.

Gwent Public Services Board

The Gwent Public Services Board (PSB) is the statutory body established by the Well-being of Future Generations (Wales) Act 2015 which brings together the public bodies in Gwent to meet the needs of Gwent citizens present and future. The aim of the group is to improve the economic, social, environmental and cultural well-being of Gwent. Working in accordance with the five ways of working, the Board has published its Well-being Assessment and Well-being Plan.

The Health Board contributes to achieving these objectives through the delivery of the Clinical Futures Strategy and the Integrated Medium-Term Plan (IMTP).

Aneurin Bevan University Health Board Members included in the membership of the Public Services Board are:

- Ann Lloyd, Health Board Chair
- Nicola Prygodzicz, Chief Executive
- Tracey Daszkiewicz, Executive Director for Public Health & Strategic Partnerships

Further detail in respect of the Gwent PSB can be found on the PSB's website.

NHS Wales Shared Services Partnership

NHS Wales Shared Services Partnership (NWSSP) was established in November 2010 to deliver economies of scale; efficiencies and consistency of quality and process for the business and professional services that were directly managed and delivered by local NHS bodies.

As a hosted organisation, NWSSP operates under the legal framework and Establishment Order of Velindre University NHS Trust. The Managing Director is the designated Accountable Officer for Shared Services in line with The Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012 and is accountable to the Director General/CEO NHS Wales and Health Boards, Special Health Authorities and Trusts through the Shared Services Partnership Committee (the Partnership Committee). The Partnership Committee meets bi-monthly and is chaired by Professor Tracy Myhill OBE. The membership is comprised of representatives from each NHS organisation, including Aneurin Bevan University Health Board.

The Partnership Committee is responsible for exercising the Velindre National Health Service Trust's functions in relation to shared services, including the setting of policy and strategy and the management and provision of shared services to Local Health Boards, Special Health Authorities and National Health Service Trusts. Several committees and advisory groups have been established to help support the governance arrangements that underpin how NWSSP operates.

Further detail in respect of NHS Wales Shared Services Partnership can be found on NWSSP's website.

THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risks; it can therefore only provide reasonable and not absolute assurances of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place for the year ended 31 March 2024 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

As Chief Executive and Accountable Officer, I am responsible for overall risk management and report to the Board on its effectiveness across the Health Board. My advice to the Board has been informed by executive officers and feedback from the Board's Committees, particularly the Audit, Risk, and Assurance Committee and the Patient Quality, Safety, and Outcomes Committee.

Executive Committee meetings provide an opportunity for executive directors to consider, evaluate, and address risk while also actively engaging with and reporting to the Board and its committees on the organisation's risk profile. The Director of Corporate Governance is the Health Board's risk lead, responsible for developing the framework, as well as the systems and processes required for risk management within the organisation. Depending on the nature of the risk, other Directors will take ownership of its management and mitigation. For example, patient safety risks are the responsibility of the Medical Director, the Director of Nursing and Midwifery, and the Director of Therapies and Health Science.

Risk Appetite

In June 2023, the Board commenced developmental work to review and redesign its risk appetite against key business domains or 'themes'. These themes were derived from feedback received from the Board on the most significant risks to the Health Board in achieving its strategic objectives.

The table below summarises the Health Board's position on its appetite for risk and the level of tolerance it is willing to accept. The full Risk Appetite Statement is available **here.**

	Risk Theme	Risk Appetite Level	Risk Appetite Description	Risk Appetite Thresholds
RISK APPETITE	Aneurin Bevan University Health Board Activities (Compliance & Safety)	Minimal	Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls	Score 8 and below
	Aneurin Bevan University Health Board Activities (Service Delivery)	Open	Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure	Score 17 and below
	People	Open		
	Transformation and Partnership working	Open		
	Financial Sustainability	Cautious	Preference for safe, though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls	Score 13 and below
	Confidence and Trust	Cautious		

The Risk Appetite Statement is an important component of the Health Board's risk management arrangements in that it provides guidance and direction in risk prioritisation and resource allocation.

The Health Board's ***Risk Appetite*** represents the overall willingness to accept risk at a strategic level, whereas ***Risk Tolerance*** refers to the level of risk that is acceptable for a specific activity or decision.

Risk appetite guides the Health Board's overall risk approach, whereas tolerance provides a more detailed and measurable framework for assessing and managing risk in specific contexts. This approach has been the driving force behind the management of strategic and operational risks, and it will be the tool used throughout the Health Board to assign risks to themes and provide a basis for determining risk management.

The Risk Management Framework

In August 2022, the Director of Corporate Governance committed to reviewing the Board Assurance Framework (BAF) to allow for closer alignment and reporting with the Corporate Risk Register (CRR).

In May 2023, the Board reviewed its corporate risk register, which included both strategic and corporate (high-level operational) risks. It was agreed that a risk separation was required to ensure that strategic risks were aligned with the Board's strategic objectives and ministerial priorities, while corporate (high-level operational) risks would be overseen by the executive directors and reported to the Board via the risk and assurance report, allowing for clear risk differentiation and greater transparency of all risks.

This approach resulted in the establishment of a Strategic Risk Register (SRR), formerly known as the BAF, which includes risks that could have an impact on strategic objectives and ministerial priorities, as well as a CRR, which includes any risks escalated from divisions or internal/external intelligence that have the potential to impact service delivery.

The new approach required the Health Board to review its risk management processes and update its Risk Management Framework, making sure that roles and responsibilities, the risk register hierarchy, and the escalation process were all clearly defined. This will allow the Health Board to mature its risk management practices while also providing improved assurance across the internal control system on an operational level.

Furthermore, the Board reviewed its risk appetite statement, as previously stated, to ensure that it was reflective of the current operating environment while also balancing the need to drive improvements and sustainability by increasing its tolerance for specific risk domains to avoid missing opportunities.

The Audit, Risk and Assurance Committee endorsed the revised Risk Management Framework, Policy, and Risk Appetite Statement at its November meeting before submitting it to the Board for formal approval in January 2024.

To support the implementation and embedding of risk management practices across the Health Board a toolkit has been developed to provide staff with the knowledge and tools to actively manage risk. These tools support the Framework, Policy and Appetite Statement and are listed below:-

- NHS 5 X 5 Risk Scoring Matrix – including thresholds for various risk domains
- Strategic / Corporate and Operational Risk Assessment Template (Risk to a Page)

- Risk Management intranet page (under development). This will contain the full Toolkit, FAQs, Bitesize learning, training schedule, etc.

Since the refreshed approach and the establishment of the Strategic Risk Register, it has been determined that a greater emphasis on assurance mapping across the Three Lines of Defence Model to demonstrate assurance sources is required, which will be carried out throughout the first and second quarters of 2024/25. Furthermore, to strengthen the internal control system, a system-wide assurance mapping exercise will be conducted in conjunction with the Quality Assurance and Performance Management Frameworks to provide the Audit, Risk and Assurance Committee (ARAC) with the assurances it requires regarding its delegated responsibilities.

In the fourth quarter of 2024/25, the ARAC will receive the findings of a risk maturity survey, which will provide intelligence on areas where risk management has evolved and is a core competency and enabler for achieving objectives, as well as highlight where resources should be focused to enable change.

The Corporate Governance Directorate has commenced a period of communication and engagement with staff to launch the Risk Management Framework. To coincide with the launch, the Head of Corporate Risk and Assurance will increase visibility across the Health Board, raising awareness and providing staff with the knowledge and skills needed to incorporate risk management into their daily processes. This is being undertaken in a structured way, meeting with departments/directorates and divisions to begin embedding the Health Board's agreed-upon approach to risk management and the escalation process to mature the Health Board's risk management practices.

Risk Management System

The Health Board's electronic risk management system and associated functionality provide a useful mechanism for operational teams to record risks, raise and escalate risks via hierarchical digital risk registers, to which the Head of Corporate Risk and Assurance has full oversight and can review the risk being escalated to ensure it is held on the appropriate risk register for management and oversight. Furthermore, the Health Board's Executive Directors hold assurance meetings with their respective Divisions to discuss management of ongoing risks and provide an additional opportunity to escalate risks. Regular engagement with executive risk owners is conducted to update risks and ensure that scoring is consistent and balanced.

The Legacy Datix module is currently used as the Health Board's risk management system. The Health Board has not yet transitioned to the RLDatix 'Once for Wales' risk management module due to functional issues which are being addressed. A national group is working to ensure the

system is fit for purpose and contains all of the functions required for a robust and effective risk management system. The group is optimistic that Datix will make the necessary improvements and that the module will be approved for use throughout Wales.

The Health Board's Risk Profile

The Director of Corporate Governance presents a full strategic risk report to each Board meeting, as well as a report to each Board Committee, which includes detailed risk assessments for the risks for which the Committee has been tasked with seeking assurance.

This report is published in the public domain to ensure transparency and openness regarding the strategic risks identified by the Health Board as potential barriers to achieving the Board's strategic priorities.

As of the end of March 2024, there were **20** strategic risks described in the Strategic Risk Register, representing the most significant risks to the Health Board in terms of potential impact on the delivery of the Board's strategic priorities. These **20** are categorised into risk levels based on their 'likelihood' and 'impact' if the risk occurs. **6** of the **20** strategic risks managed by the Health Board fall outside of the risk domain's appetite, as illustrated below.

Risk Level & Score	Number of Risks	Number of Risks outside of Appetite
Extreme (15 – 25)	**7**	**3**
High (8 – 12)	**11**	**3**
Moderate (4 –8)	**2**	**-**
Low (1 – 3)	**-**	**-**

The Table below illustrates where the **six** risks outside of appetite sit.

	Risk Theme	Risk Appetite Level	Number of Risks outside of Appetite Level
RISK APPETITE	**Compliance & Safety**	**Minimal** Score 8 and below	**5**
	Financial Sustainability	**Cautious** Score 13 and below	**1**

A copy of the latest Strategic Risk Report presented to Board in March 2024 is available here. The risks contained within this have been subject to

Executive risk owner scrutiny, challenge, and review. Robust assessments of the Health Board's internal control system were also undertaken, alongside a review of all sources of assurance related to each risk. Work is ongoing to provide enhanced assurance of risks outside of appetite, this will be done by undertaking deep dives of the risks outside of appetite and developing action plans to enhance control and mitigate the likelihood / impact.
Changes to the risk assessment template, as well as the implementation of a dashboard, have allowed the Board to gain a better understanding of risk appetite in relation to the risk profiles for which it is responsible. The revised template for Committees and the Board provides a high-level overview of the risks being managed within the Committee or Board's portfolio and whether they are being managed within the agreed risk appetite level, and where risks are not managed within agreed limits, that robust plans and objectives are in place to de-escalate.

Recognising that more work needs to be undertaken to improve control and assurances across all risks, an overarching, high-level indication of the level of assurance the Board can derive from this iteration of the strategic risk report is provided below:

Overall Assurance on the Management of Risk		
Nil	**Satisfactory**	**Considerable**
	X	

This means that the Board can take a satisfactory level of assurance that the strategic risks on the Strategic Risk Register (at March 2024), which represent significant risks to the IMTP's delivery, are effectively managed. The Board could also be assured that the internal control system in place to manage these risks is considered satisfactory.

The Executive Team reviews strategic and corporate risks on an annual basis, conducting an in-depth review of all risks to ensure they are appropriately articulated, scored, and moderated. This work will be presented to the Board in the second quarter, 2024/25.

Risk & Assurance Related Internal Audit Reviews

The Audit, Risk and Assurance Committee received two risk management audits with a reasonable assurance rating during the 2023/24 financial year. The reviews were designed to give the Board assurance that appropriate risk management arrangements are in place within the Divisions (at the operational level).

The report issued in April 2023 included four recommendations (2 low and 2 medium), with the report issued in April 2024 making one medium recommendation that was not material in nature and will be completed as

part of the transition to the Once For Wales Datix Risk Module once it is implemented in the Health Board.

Emergency Planning

In accordance with the statutory duties of the Civil Contingencies Act (2004) and Emergency Planning Guidance issued by Welsh Government the Health Board have in place emergency plans, business continuity arrangements, health protection response plans and supporting documents. The Board agreed a refreshed Major Incident Plan at its meeting in March 2024. The Health Board has also adopted the learning from the 2023 business continuity audit and multi-agency exercises to support organisational preparedness.

THE CONTROL FRAMEWORK

Quality Governance

Patient Safety, Quality and Experience

As an NHS Wales organisation, there are clear expectations set out for the quality standards we must maintain. These are set out through the:

- Health and Social Care (Quality and Engagement) (Wales) Act 2020;
- A Healthier Wales;
- Core Commissioning Requirements.

Putting quality and safety above all else is the first NHS Wales core value. This focus has been strengthened through the Health and Social Care (Quality and Engagement) (Wales) Act (2020). Enhancing quality, honesty and transparency, the legislation provides the Health Board with a Duty of Quality, Duty of Candour, and establishes a Citizen Voice - Llais, enriching engagement with our patients, relatives, carers, staff and communities. Llais is an independent body and its free Advocacy service can provide information, advice and support to members of the public.

In 2023 the Health Board published and implemented two Strategies:

- **The Quality Strategy**, which serves as a blueprint for patient safety and quality for the next three years, placing quality and safety at the forefront of all we do, while at the same time recognising that challenges to patient safety and quality change and emerge over time. We will remain agile in responding flexibly to emerging safety and quality issues as they arise. It outlines our improvement objectives for the next three years as well as the frameworks that will support that activity. Our culture values quality, and we are committed to continuous improvement.

- **The Patient Experience and Involvement Strategy** was developed as a direct result of staff, patient, family and carers feedback, telling us what matters to them. Our teams and our staff members have a passion to improve people's experiences within our services and it is important to us that learning from experience is at the heart of the organisation.

These Health Board Strategies have been developed from the experiences of our patients, relatives, carers, staff and communities to focus on improvement, planning and assurance in the right areas. This is aligned with the objectives and aims of the Duty of Quality and in the context of meeting our obligations under the Duty of Candour.

Both Strategies outline our goals and objectives to improve services, clinical effectiveness, safety and people's experiences. It encompasses our intent to engage patients, families, carers, staff and the wider community, with a commitment to listen to feedback, learn from it, and therefore improve healthcare across all of our services.



The Quality vision of Aneurin Bevan University Hospital Board is to be "widely recognised for delivering the Health and Care Quality Standards". Our first and most important commitment to our patients is to keep them safe. Over the next three years, the Quality Strategy will improve the delivery within these Quality Standards, while continuing to improve patient and staff experience and outcomes.



Our ongoing commitment to quality and safety:

- Aneurin Bevan University Health Board will be a learning organisation where staff members work towards delivering high quality clinical care every day.
- We will strive to better understand our systems of care, build capability through an all teach/all learn philosophy, encourage innovation and engage patients, relatives, carers, staff and communities in improvement endeavours, whilst learning from mistakes.
- We will ensure that quality is embedded throughout the organisation creating a culture of openness and transparency where people are supported to raise concerns.
- Our patients, relatives, carers, staff and communities will be encouraged to work alongside us to achieve this vision.

To date we have achieved a number of milestones, including:

- Implementing the Quality and Engagement Act including the Duty of Candour and Duty of Quality.
- Developing a reporting framework and quality outcomes framework to align with the six domains of quality.
- Reviewing Quality Safety and Patient Experience structures within divisions/directorates, formalising lines of responsibility, accountability, escalation, and assurance.

Ongoing work will continue on:

- Setting out the core evidence that will be considered by each Committee (service/division to sub-committee of board levels) to provide assurance on delivery of Health and Care Standards
- Developing a corporate clinical audit plan to address any gaps in assurance
- Develop an Annual Report for each Health and Care Standard, scheduled for consideration by Patient Quality Safety and Outcomes Committee (PQSOC)
- Strengthened assurance mechanisms for commissioned services
- Standardising resources, role profiles and appraisal arrangements for QPS leads
- Standardised QPS agendas (evidence and risk based)
- Clearly defining the support from corporate teams associated with the quality safety and patient experience agenda and setting the expectation
- Introducing the integrated decision framework with Board development and the identification of priority areas for implementation
- Ensuring that the groups and committees across the Health Board are able to be responsive in promoting quality and patient safety at all levels of the organisation

Learning

The Health Board's commitment to learning and improvement is demonstrated in our Listening and Learning Framework, ensuring effective listening, learning and improving. The Framework brings structure to the way learning from incidents and person-centred feedback is captured. Ensuring learning follows a consistent process across the Health Board. This strengthens our commitment to promoting a culture which values and facilitates learning and in which the lessons learned are used to improve the quality of patient care, safety and experience, as well as the experience of our workforce. We are developing a repository for learning which will allow us to review how learning will be identified, stored, triangulated, shared, disseminated and implemented in practice to facilitate and embed a culture of appreciative enquiry and continually improving health care services and the experience of our workforce.

We aim to become a true learning organisation to improve patient safety, experience and clinical effectiveness. We will respond to learning and guidance from our Quality Management System, local and national groups, adapting our plans and priorities to ensure we are doing the right things.

Key areas for delivery include:

- Identification of key quality and patient safety priorities and sources of information, to inform the learning and education agenda guided by the views of service users.

- Collaboration between corporate and educational teams to support the development of health professionals around key quality and safety priorities.
- Facilitation of multi professional approaches to education aligned to quality, safety and patient experience.
- Representation of learning and education on key quality and patient safety groups across the organisation.
- To facilitate divisions and directorates to prepare a standardised annual improvement strategy based on information collated from review of complaints, incidents, surveys and audits.
- To build capacity within teams to develop co-produced digital patient stories to support listening and learning Standardisation of training and education and competency records to avoid unwarranted variation in education approaches.
- Introducing a Covid Investigation Team to review cases of nosocomial transmission to identify breaches and ensure learning.

Quality Management System

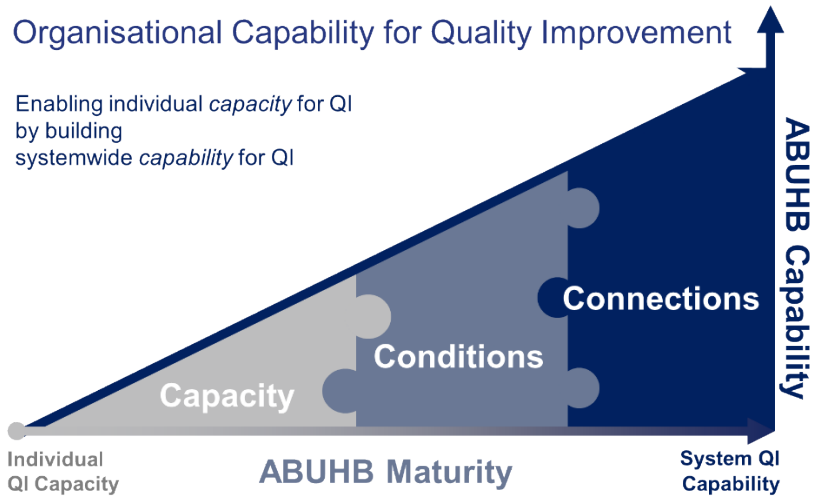
The key to delivery of our plans is to develop a 'Quality Management System' approach to embed a culture of learning: a culture where people listen, think, feel and act 'quality' - promoting openness and learning, continuous improvement and service transformation. This includes work to embed positive cultures of continuous improvement and working together. We will further develop our Quality Management System to routinely set meaningful targets, monitor, measure and report performance to ensure we provide excellent standards of care and set quality goals to continuously improve the services we provide.

Quality Improvement (QI)

"Quality improvement is about giving the people closest to issues affecting care quality the time, permission, skills and resources they need to solve them. It involves a systematic and coordinated approach to solving a problem using specific methods and tools with the aim of bringing about a measurable improvement."

Organisational QI Capability is "the organisational ability to intentionally and systematically use improvement approaches, methods and practices, to change processes and products/services to generate improved performance".

We will grow and mature our organisational capability for Quality Improvement (QI), by building capacity, conditions and connections which will enable staff to use QI methodology for solving complex problems, and in so doing provide a consistent approach to testing change ideas, learning and informing our decisions.



Data for Quality and Improvement

We will measure our progress and guide our actions towards becoming a learning organisation. Data for Quality and Improvement - both qualitative and quantitative data - are critical in understanding the quality-of-care provision and in evaluating and guiding improvement. Increasing the availability of data and the capability and capacity to analyse, understand and utilise the data will ensure a focus on quality.

Information Governance

Information is a vital asset, both in terms of the clinical management of individual patients and the efficient management of services and resources. Information Governance is about setting high standards for handling this information and giving the organisation the tools to achieve those standards.

The Health Board has a range of key roles that have responsibilities in relation to the information that it holds, uses and shares. The Medical Director is the Caldicott Guardian, the Director of Digital is the Senior Information Risk Owner (SIRO) and the Head of Information Governance is the Data Protection Officer (DPO).

During 2023/2024 the Health Board continued to develop the forums for the organisation to consider information governance requirements and to provide a consistent way in which it is managed. These forums allow the facilitation of processes and communications which ensures that all Data Protection obligations are met. Dashboards are produced to provide support and assistance ensuring compliance with training, dealing with complaints, incident and breach management. Annual reports are produced on progress made throughout the year and disseminated to the relevant divisions and boards.

The Health Board continues to be proactive in using the NHS Wales IG Toolkit to ensure consistency of policy, standards and interpretation of the law and regulation across NHS Wales organisations. The Health Board achieved a score of 95% for the last year.

The Wales Accord on the Sharing of Personal Information (WASPI) framework is embedded in the way in which the Health Board shares relevant information with its partner organisations.

During 2023/2024 there was a 6% increase in the number of Subject Access Requests (SARs) compared to the previous year. The largest proportion of requests received continues to be made by solicitors and legal services.

During this year there was a 12% increase in IG incidents reported by staff from the previous year.

There were 11 complaints made to the Information Commissioners Office (ICO) by complainants, with 9 not upheld and 2 awaiting a final outcome at the time of writing.

In 2023/24, there were no serious lapses in data security reported to the ICO by the Health Board

The Corporate Governance Code

The Corporate Governance Code currently relevant to NHS bodies is 'The corporate governance in central government departments: code of good practice' (published 21 April 2017). The Health Board, like other NHS Wales organisations, is not required to comply with all elements of the Code, however, the main principles of the Code stand as they are relevant to all public sector bodies. The Corporate Governance code is reflected within key policies and procedures. Further, within our system of internal control, there are a range of mechanisms in place that are designed to monitor our compliance with the Code. These include Self-assessment; Internal and External Audit; and Independent Reviews.

The Board is clear that it is complying with the main principles of the Code and is conducting its business openly and in line with the Code, and that there were no departures from the Code as it applies to NHS bodies in Wales. A copy of the current self-assessment against the code is provided as **Attachment Three**.

Planning Arrangements

The Board approved the IMTP at its meeting of 29th March 2023 for submission to Welsh Government. The Plan reflected constructive discussions with Welsh Government ahead of submission informing how the plan was developed. In approving the Plan at the March 2023 meeting, the

Board recognised the significant challenges and risks going forward and in particular the financial context in which the Board were operating in to deliver the plan, with the Duty of Quality and Duty of Candour at the forefront alongside the drive for efficient and effective service delivery. The plan maintained a three year focus given the emphasis on long term sustainability but with a greater level on detail on year one delivery given the scale of challenge and ministerial expectations. Overall, the plan was based on a realistic assessment of delivery for the next three years, it was optimistic in outlook, recognising the need to build on the transformation of services over the last few years, and it focussed on sustainably making change to meet the long term needs of our communities.

On 25th August 2023 the Board received correspondence from Welsh Government noting that as the Board was unable to submit a balanced integrated medium-term plan (IMTP) for 2023-26, in line with section 175(2A) of the National Health Service (Wales) Act 2006 (as amended by NHS Finance (Wales) Act 2014) and in accordance with the NHS Planning Framework, Welsh Government would treat the 2023/4 submission as an Annual Plan.

In December 2024 the NHS Wales Planning Framework was issued by Welsh Government confirming the policy requirements of the 2024/25 planning cycle. As a result, in February 2024 the Health Board issued an Accountable Officer letter to Welsh Government confirming that, due to the ongoing financial challenges, the Health Board would be submitting an Annual Plan for 2024/25 with a three-year intent to balance the immediate system sustainability challenges with the population health and care needs.

In March 2024, the Board received and approved the Annual Plan for 2024/25, which was presented in the context of significant financial and operational challenges. The Annual Plan 2024/25 sets out a three-year intent to recognise the focus required to deliver performance and financial improvements over the next year, the medium-term ambitions to achieve financial and service sustainability and the longer-term ambitions to reduce the health inequalities experienced by our communities.

On 3rd May 2024, Welsh Government confirmed that the Annual Plan 2024/25, as approved by the Board in March 2024, was unsupportable. At the time of writing this report, the Health Board continues to review its Annual Plan 2024/25 in light of Welsh Government's feedback.

MANDATORY DISCLOSURE STATEMENTS

Equality, Diversity & Human Rights

It is a key priority for the Health Board to become a truly inclusive organisation which celebrates its diverse workforce, and where staff feel they are treated equally regardless of their ethnic background, gender, religion, sexual orientation, disability or age.

During the reporting period, extensive engagement and consultation has been carried out to shape our revised Strategic Equality Plan (2024-2028) . The Plan, published in March 2024, sets out our vision, aims and objectives to create a fair, just and equal culture across the Health Board over the next four years. 3 Objectives (what we call the 3Ps of inclusion) will form the basis of our proposed Strategic Equality Plan for 2024 -2028; **Our Patients, Our People and Our Population.**

The Health Board's Annual Equality Report outlines the work that was undertaken from 1 April 2023 to 31 March 2024 to progress the last year of our previous Strategic Equality Objectives. We also have duties to publish information about our workforce and how we use this data and this report includes the Equality Monitoring data based on a snapshot as of 31 March 2023.

Regulations introduced in 2017 require public, private and voluntary sector organisations, with 250 or more employees on a specified 'snapshot date' relevant to their sector, to report annually on their gender pay gap, using six different measures. A snapshot of 31 March 2023, identified a gender pay gap within the Health Board, showing a median pay difference in favour of males of 16.20%, down from 18.72% (31 March 2022).

We will be working in collaboration with Cardiff University during 2024 to undertake the analysis and action required by the 'equal pay duty', to ensure its effectiveness and to make a lasting impact on gender pay disparities in the Health Board.

To demonstrate our anti-racist commitment, the Health Board has committed to voluntarily publishing an annual Ethnicity Pay Gap Report. In the absence of a mandatory framework, we have aligned our reporting framework with the gender pay gap. However, in recognising the complexity of ethnicity pay reporting compared with gender pay reporting, we have made some changes to account for the different data sets.

Analysis of the Ethnicity Pay Gap data will inform the actions of our Equality Objectives to include positive action initiatives. We aim to continue to reduce our gender and ethnicity pay gap year on year, to create greater equality in our pay frameworks.

In addition to our annual reporting cycle, governance arrangements for ED&I ensure the board of directors receive regular assurance that the Health Board is meeting its Public Sector Equality Duty (PSED) requirements.

A review of our current Equality Impact Assessment (EqIA) process, during the reporting period, has identified that a structured program of embedding EQIA practice throughout the organisation is needed and that the practice of completing an EQIA should also be built into strategic and operational plans across directorates.

Governance arrangements have been put in place for scrutinising and approving EQIA's in the form of an EQIA Panel and an auditing process is being developed to better understand our levels of compliance.

Pensions Scheme

I can confirm that as an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employers' contributions and payments into the Scheme are in accordance with Scheme rules and that the member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations. Further detail in this regard is included within the provisions note within the 2023/24 Financial Statements (Note 20).

Carbon Reduction Delivery Plans

The Health Board is unable to confirm compliance with the following statement:

"The organisation has undertaken risk assessment and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements as based on UKCIP 2009 weather projections to ensure that the organisation's obligation under the Climate Change Act and the Adaptation Reporting requirements are complied with."

As national work progresses with Welsh Government, and through Local Partnerships to develop an Adaptation Toolkit for health and social care organisations in Wales; which when released will allow the Health Board to undertake climate risk assessments using weather projection scenarios. The Health Board will then revisit these reporting requirements when appropriate and are able to comply.

Counter Fraud, anti-corruption and anti-bribery matters.

Aneurin Bevan University Health Board is committed to reducing the level of fraud, bribery and corruption within the NHS to an absolute minimum and keeping it at that level, freeing up public resources for better patient care.

The Health Board's Counter Fraud Team undertake proactive/preventative work with the intention of safeguarding the organisation from economic crime. Further information on the valuable work undertaken is available in the Counter Fraud bribery and Corruption Report 2022/23. – **Add link to 2023/24 report once available (May)**

Quality of Data

The Health Board makes every attempt to ensure the quality and robustness of its data and has regular checks in place to assure the accuracy of information relied upon. However, it is recognised that the multiplicity of systems and data inputters across the organisation means that there is always the potential for variations in quality, and therefore always scope for improvement. We have an on-going data quality improvement approach which routinely assesses the quality of our data across key clinical systems. Good quality clinically coded data plays a fundamental role in the management of hospitals and services. Coded data underpins much of the day to day management information used within the NHS and is used to support healthcare planning, resource allocation, cost analysis, assessments of treatment effectiveness and can be an invaluable starting point for many clinical audits.

The Board relies upon independent and objective assurances, such as those provided by auditors and inspectors, to comment upon the effectiveness of the Board's assurance system. This assurance system includes reporting on financial performance, operational performance and quality of and associated outcomes.

Ministerial Directions & Welsh Health Circulars

The Welsh Government has previously issued Non-Statutory Instruments and reintroduced Welsh Health Circulars (WHCs) in 2014/15. Details of these and a record of any ministerial directions given is available on the Welsh Government website. A full detail of the WHCs and Ministerial Directions issued to the Health Board in 2023/24 and the Health Board's responding action is included at **Attachment 2**.

There was one Ministerial Direction issued in December 2019, to address the operational challenges arising as a consequence of pension tax arrangements. Further detail in this regard is included in provisions within the 2023/24 Financial Statements (Note 20).

Modern Slavery Act 2015 – Transparency in Supply Chains –

The Health Board is fully committed to the Welsh Government Code of Practice Ethical Employment in Supply Chains. This has been established by the Welsh Government to support the development of more ethical supply chains to deliver contracts for the Welsh public sector and third sector organisations in receipt of public funds.

The code of practice sets out a number of commitments and Procurement Services on behalf of the Health Board has commenced the preparation of an action plan so that it can monitor progress against these. As an example, The Health Board have included the requirement for all suppliers to meet the Act in our standard NHS Terms and Conditions of contract.

Also, following the Transparency in Supply Chains consultation (2019), the UK Government has committed to extend section 54 of the Modern Slavery Act 2015 to public bodies in England and Wales with a budget of £36m or more – This requires organisations to produce annual statements by 30th September of each financial year, that provide details of steps taken to prevent modern slavery in their operations and supply chain. A draft statement is being compiled by Procurement Service and Legal/Risk in readiness for the 30th of September deadline, reflecting the work to date, any further and emerging risks and appropriate mitigations.

The procurement function is a key area for ethical employment in supply chains. This is run by NHS Wales Shared Services Partnership (NWSSP) which is hosted by Velindre University NHS Trust (Velindre). More information can be found on the work done on the Health Board's behalf by NWSSP on the Shared Services Partnership website.

REVIEW OF EFFECTIVENESS OF SYSTEM OF INTERNAL CONTROL

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the system of internal control is informed by the work of the internal auditors, and the executive officers within the organisation who have responsibility for the development and maintenance of the internal control framework, and comments made by external auditors in their audit letter and other reports.

The Board has adopted a structured approach to risk management, whereby risks are identified, assessed and controlled, and if appropriate, escalated or de-escalated through the governance mechanisms of the organisation.

During 2023/24, the Board's Audit, Risk and Assurance Committee and, Patient Quality, Safety and Outcomes Committee played a key role in monitoring the effectiveness of internal control and the process for risk management. During 2023/24 work was undertaken to strengthen the reporting of risks to the Board and its Committees, with a revised Risk

Management Framework approved by the Board in January 2024. Work to fully embed the revised framework will continue in 2024/25. The Board's Quality Strategy, approved in March 2023 and updated in February 2024, will ensure that the work of all regulators, inspectors and assurance bodies is mapped and evidenced in our assurance framework so that the Board is fully aware of this activity and the level of assurance it provides. We will also continue to strengthen arrangements for monitoring and reporting progress in implementing recommendations arising from the work of auditors.

The Health Board also uses reports from Healthcare Inspectorate Wales, the Welsh Risk Pool and other inspectorates and regulatory bodies to inform the governance and assurance approaches established by the organisation. A tracking mechanism for these recommendations is also in place and progress in delivering these recommendations is overseen by the Patient Quality, Safety and Outcomes Committee via updates in respect of Inspections.

INTERNAL AUDIT

Internal audit provides the Chief Executive/Accountable Officer and the Board, via the Audit, Risk and Assurance Committee with a flow of assurance on the system of internal control. I have commissioned a programme of audit work which has been delivered in accordance with public sector internal audit standards by the NHS Wales Shared Services Partnership. The scope of this work is agreed with the Audit, Risk and Assurance Committee and is focussed on significant risk areas and local improvement priorities.

The overall opinion by the Head of Internal Audit on governance, risk management and control, is a function of this risk-based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

UPDATE SECTION ONCE HOIA Opinion available

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The assurance sections that follow provide a brief summary of the scope of the Internal Audit Reviews that have been completed and received by the Committee during the financial year 2023-24.

Substantial Assurance

In the following review areas, it was reported that the Board could take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively.

The few matters that required attention were compliance or advisory in nature with low impact on residual risk exposure.

Cyber Security (2022 - 2023)
Executive Lead – Chief Executive Officer

The review sought to provide assurance that the organisation is working to improve its cyber security position, and that appropriate reporting is in place that shows the current status.

Unified Breast Unit at Ysbyty Ystrad Fawr (2023-2024)
Executive Lead – Chief Operating Officer

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

Reasonable Assurance

In the following review areas, it was reported that the Board could take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively.

Some matters required management attention in either control design or operational compliance and these had low to moderate impact on residual risk exposure until resolved.

Reports included within the 2022/23 Internal Audit Plan, and reported in the Annual Governance Statement 2022/23, reported to the Audit, Risk and Assurance Committee in 2023/24:

Robotic Process Automation (2022-2023)

The review sought to ensure that the organisation has an appropriate process in place to securely develop the Robotic Process Automation (RPA) function.

IT Strategy (2022-2023)

The review sought to ensure that the organisation has developed an appropriate target operating model to enable to delivery of the Digital Strategy.

Financial Sustainability (2022-2023)

The review sought to review the key financial management controls within Aneurin Bevan University Health Board including the development and monitoring of savings programmes required for financial sustainability.

Risk Management (2022 - 2023)
The review sought to provide an opinion of effectiveness of the risk management arrangements in place within a sample of divisions. To complete this, we considered key sections of the Risk Management Strategy and Framework.

Monitoring Action Plans (2022-2023)
The review sought to review the arrangements in place within the Health Board for the logging, tracking and implementation of actions arising from external inspectorates (specifically Health Inspectorate Wales (HIW) and Health and Safety Executive (HSE).

Development of a Regional Radiotherapy Satellite Centre (RSC) at Nevill Hall Hospital (2022-2023)
The audit sought to review the delivery and management arrangements in place to progress the development of a Regional Radiotherapy Satellite Centre (RSC) at Nevill Hall Hospital, and the performance to date against its key delivery objectives i.e. time, cost, and quality.

Infection Prevention and Control (2022-2023)
The review sought to assess adherence to organisational policies and the Health and Care Standards in Wales.

Integrated Wellbeing Networks (2022-2023)
The review sought to provide an opinion on the Health Board's plan to further develop Integrated Wellbeing Networks across the region.

Dementia Services (2022-2023)
The review sought to ensure that Aneurin Bevan University Health Board has an appropriate process for Dementia Services.

Contract Management (2022-2023)
The audit sought to provide a review of the effectiveness of the management of operational contracts entered into by Aneurin Bevan University Health Board.

Mental Health Transformation (2022-2023)
The audit sought to provide a review of the controls in place for the projects that support the transformation of mental health services within Aneurin Bevan University Health Board.

Royal Gwent Hospital – Redevelopment & Expansion of Endoscopy Services (2022-2023)
The audit sought to review the delivery and management arrangements in place to progress the Royal Gwent Hospital Endoscopy Redevelopment & Expansion of Endoscopy Services project, and the performance to date against its key delivery objectives i.e., time, cost, and quality.

Bank Office and Temporary Workers (2022-2023)
The review sought to provide an opinion over the Bank Office and Temporary Workers process. As well as undertook a follow-up audit work on the process for contract and off-contract agency nursing.

Reports included within the 2023/24 Internal Audit Plan:

IMPT (2023-2024)
The review sought to provide an opinion over the controls to ensure the delivery of the IMTP / strategic objectives.

Safeguarding (2023-2024)
The audit sought to review the arrangements in place to ensure that the Health Board discharges its statutory responsibilities Safeguarding.

Clinical Coding (2023-2024)
The review sought to provide an opinion over the timely recording of Finished Consultant Episodes (FCE), in accordance with clinical coding standards.

Business Continuity Planning (2023-2024)
The review sought to review the arrangements that the Health Board has in place to maintain business continuity in the event of a critical incident, including how learnings from the Covid-19 pandemic have been Considered.

Integrated Performance Dashboard – Data Quality (2023-2024)
The review sought to assess the accuracy of data utilised within Integrated Performance Report (IPR) dashboard. In particular, focused on the accuracy of a sample of data used within the reporting of key metrics within the IPR dashboard i.e. that the source data utilised was consistent with the figures within the dashboard.

Stakeholder Engagement on IT Projects (2023-2024)
The audit sought to review the framework in place for stakeholder engagement on key IT projects.

Asset Management (2023-2024)
This review provided an opinion on the effectiveness of the Health Board's processes to create and maintain accurate and up-to-date records of its equipment assets. The review focused on the roll-out of Radio Frequency (RFID) tagging.

Risk Management & Assurance (2023-24)
This review sought to assess the effectiveness of the risk management and assurance arrangements in place within the Health Board, to ensure that strategic objectives are achieved. This review focused on the management

of risks within the Digital Services Directorate

Long Term Sickness Absence Management (2023-24)
The review sought to determine compliance with the NHS Wales Managing Absence at Work Policy and whether the Health Board is acting promptly and managing the interests of all parties within the process of managing long term sickness absence.

Limited Assurance

In the following review areas, it was reported that the Board could take **only limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, were suitably designed and applied effectively.

More significant matters required management attention with moderate impact on residual risk exposure until resolved.

The Management response and action plan to respond to the issues and weaknesses identified, which form part of the final reports, are considered by the Audit, Risk and Assurance Committee. The Committee monitor progress in line with agreed timescales via the Audit Recommendations Tracker.

In addition for all limited assurance rated reports, executive leads attend the Audit, Risk and Assurance Committee to provide assurance on the actions identified.

Reports included within the 2022/23 Internal Audit Plan, and reported in the Annual Governance Statement 2022/23, reported to the Audit, Risk and Assurance Committee in 2023/24:

Discharge Planning *(2022/23)*
This audit was undertaken to provide an opinion on the discharge planning process of the Health Board. It has focussed on the management and delivery of planned discharges and has included sample testing of patients admitted during April and May 2022.

The review found that discharge planning practices were not supported by the out-of-date Discharge Policy, there was no compliance audit programme and reporting. Furthermore, the evidential support of the discharge process was lacking, based on the results of the sample testing.
In addition, Internal Audit raised comments on the simple and complex pathways approach, the use of checklists, and improvement in the reporting, analyses and actions to address avoidable re-admissions.

An Action Plan is in place to address the recommendations. Collaboration with local authority colleagues has been established to allow the Health Board to begin formally reporting the new Welsh Government data set that

was required in relation to delayed discharge; however, the data required validation with LA colleagues.

Tredegar Health & Wellbeing Centre *(2022-23)*
The audit sought to review the management and governance arrangements in place to progress the Bevan Health & Wellbeing Centre.

An action plan to respond to the recommendations has been implemented, and the Centre opened to patients in January 2024.

Reports included in the 2023/24 Internal Audit Plan:

Facilities (2023-2024)
The review sought to provide assurance over whether appropriate stock processes are in place and whether applicable controls within the process for allocating/approving bank shifts are effective.

The main areas of concern raised during the audit related to the management of stock process. A Management Plan was in place and the team are committed to ensuring completion within the agreed timescales.

Estates Condition (2023-2024)
The audit sought to evaluate the arrangements put in place by the UHB to identify and manage key risks associated with the existing estate and the implementation of resulting strategies to manage/mitigate the risk.

Overall limited assurance was determined, notably due to the concerns that identified estate risks cannot be managed within existing funding. This assurance opinion is in line with that determined across NHS Wales, given the common challenges faced by each organisation.

A management action plan is in place to respond to the recommendations, with work ongoing to develop clearer future plans and to determine areas of prioritisation.

Assurance Rating Not Applicable

The following reviews were undertaken as part of the audit plan and reported or closed by correspondence without the standard assurance rating indicator, owing to the nature of the audit approach.

Reports included within the 2022/23 Internal Audit Plan, and reported in the Annual Governance Statement 2022/23, reported to the Audit, Risk and Assurance Committee in 2023/24:

Clinical Futures - Care Closer to Home (2022-2023)
The review sought to provide Aneurin Bevan University Health Board with a consolidated summary of audit work reported as part of the 2022/23

Internal Audit Plan that covers the area of Clinical Futures – Care Closer to Home. Whether the Health Board is on track to implement its overall objective of Care Closer to Home.

Reports included in the 2023/24 Internal Audit Plan:

Putting Things Right (2023-2024)
To review sought to determine if there are alternative processes or approaches that can be adopted by the Health Board to improve the overall management of Putting Things Right.

Follow-up of High Priority Recommendations (2023-2024)
The review sought to assess whether high-level internal audit recommendations have been implemented and the completeness and accuracy of the updates provided to the Committee via the Audit Recommendation Tracking Tool (the 'Tracker')

Monitoring and Implementation of Audit Recommendations

At the April 2022 meeting, the Audit, Risk and Assurance Committee received a Standard Operating Procedure (SOP) that outlined the purpose of the internal and external recommendation tracker process and provided a clear rationale as to how this benefits the organisation. The Committee adopted this SOP and since April 2022, a report on audit recommendations has been submitted to each meeting.

The Committee has retained a focus on implementing audit recommendations and in February 2024, 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.

Head of Internal Audit's Opinion for 2023/24

To be added when available

EXTERNAL AUDIT: AUDIT WALES STRUCTURED ASSESSMENT

The Audit Wales 2023 Structured Assessment work reviewed the Health Board's corporate governance and financial management arrangements, particularly the progress made in addressing the previous year's recommendations.

Overall, the Audit Wales report stated:

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

The report went on to say that:

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

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

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

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

Copies of reports produced by Audit Wales can be accessed via the following link: Audit Wales Publications.

CONCLUSION

As Accountable Officer for Aneurin Bevan University Health Board, based on the assurance process outlined above, I have reviewed the relevant evidence and assurances in respect of internal control. I can confirm that the Board and its Executive Directors are alert to their accountabilities in respect of internal control and the Board has had in place during the year a system of providing assurance aligned to corporate objectives to assist with identification and management of risk.

During 2023/24, the Health Board proactively identified areas requiring improvement and requested that Internal Audit undertake detailed assessments in order to manage and mitigate associated risks. Work will continue in 2024/25 to ensure implementation of recommendations arising from audit reviews, in particular where a limited assurance rating is applied. Work will also continue in 2024/25 to further embed risk management and assurance arrangements at a corporate and operational level. Implementation of further improvements identified by the Board through its self-assessment process, will see a further strengthening of the Board's effectiveness and the system of internal control in 2024/25.

This Annual Governance Statement confirms that Aneurin Bevan University Health Board has continued to mature as an organisation and, whilst there are areas for strengthening, no significant internal control or governance issues have been identified. The Board and the Executive Team has had in place a sound and effective system of internal control that provides regular assurance aligned to the organisation's strategic objectives and strategic risks. Together with the Board, I will continue to drive improvements and will seek to provide assurance for our citizens and stakeholders that the services we provide are efficient, effective and appropriate, and are designed to meet patient needs and expectations.

It is disappointing that in 2023/24, Aneurin Bevan University Health Board was moved into 'Targeted Intervention' for planning and finance and 'Enhanced Monitoring' for performance and outcomes related to urgent and emergency care pathways resulting in extended waits for patients in ambulances and emergency department clinical assessment at the Grange University Hospital. Alongside the targeted action the Health Board is taking to deliver in-year improvements is the clear and emerging priorities for the strategic and tactical planning and reconfigurations required for services and estates to achieve sustainable services and financial balance by 2026/27. The Health Board maintains a relentless focus on recovering its position of being in routine performance monitoring.

It is widely known that the demands on the health and care system remain significantly pressured, increasing health inequalities, and sustained economic and cost of living challenges. The Health Board will therefore need to continually reflect and respond to the demands and challenges it faces in 2024/25 and beyond. I will ensure our Governance Framework considers and responds to this need.

Signed:

Nicola Prygodzicz
Chief Executive

Dated: XX 2024

Attachment One

The Board has been constituted to comply with the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009. In addition to responsibilities and accountabilities set out in terms and conditions of appointment, Board members also fulfil Champion roles where they act as ambassadors for these matters.

Name	Position and Area of Expertise	Dates (if not full year)	Board Committee Membership	Attendance	Champion Role
Independent Members					
Ann Lloyd	Chair		Chair of the Board	6 out of 6	
			Chair, Remuneration and Terms of Service Committee	3 out of 3	
			Chair, Partnerships, Population Health and Planning Committee	4 out of 4	
Pippa Britton	Vice Chair	(interim prior to 3rd May)	Member of the Board	5 out of 6	Mental Health
			Chair, Patient Quality, Safety and Outcomes Committee	6 out of 6	
			Chair, Mental Health Act Monitoring Committee	4 out of 4	
			Vice Chair, Remuneration and Terms of Service Committee	3 out of 3	
Shelley Bosson	Independent Member (Community)		Member of the Board	6 out of 6	Infection Prevention and Control
			Member, Audit, Risk and Assurance Committee	6 out of 6	
			Member, Finance and Performance Committee	3 out of 4	
Louise Wright	Independent Member (Trade Union)		Member of the Board	4 out of 6	Children and Young People
			Vice Chair, Patient Quality, Safety and Outcomes Committee	5 out of 6	

Name	Position and Area of Expertise	Dates (if not full year)	Board Committee Membership	Attendance	Champion Role
			Chair, People and Culture Committee	3 out of 3	
			Member, Remuneration and Terms of Service Committee	3 out of 3	
			Vice Chair, Charitable Funds Committee	4 out of 4	
Richard G Clarke	Independent Member (Local Authority)		Member of the Board	3 out of 6	
			Vice Chair, Audit, Risk and Assurance Committee	5 out of 6	
			Chair, Finance and Performance Committee	4 out of 4	
			Member, Partnerships, Population Health and Planning Committee	3 out of 4	
Professor Helen Sweetland	Independent Member (University)		Member of the Board	6 out of 6	
			Member, Patient Quality, Safety and Outcomes Committee	6 out of 6	
			Member, People and Culture Committee	2 out of 3	
Paul Deneen	Independent Member (Community)		Member of the Board	6 out of 6	Equality
			Member, Audit, Risk and Assurance Committee (until August 2023)	3 out of 3	
			Member, Patient Quality, Safety and Outcomes Committee	6 out of 6	
			Vice Chair, People and Culture Committee	3 out of 3	
			Member, Mental Health Act Monitoring Committee	4 out of 4	
			Chair, Charitable Funds Committee	4 out of 4	
Iwan Jones			Member of the Board	6 out of 6	

Name	Position and Area of Expertise	Dates (if not full year)	Board Committee Membership	Attendance	Champion Role
	Independent Member (Finance)		Chair, Audit, Risk and Assurance Committee	6 out of 6	
			Vice Chair, Finance and Performance Committee	3 out of 4	
			Member, Remuneration and Terms of Service Committee	3 out of 3	
			Member, Charitable Funds Committee	4 out of 4	
Dafydd Vaughan	Independent Member (Digital)		Member of the Board	6 out of 6	
			Member, People and Culture Committee	3 out of 3	
			Member, Finance and Performance Committee	4 out of 4	
			Member, Partnerships, Population Health and Planning Committee	4 out of 4	
Martin Blakebrough	Independent Member (Third Sector)	From 03/05/2023			
Penny Jones	Independent Member (Community)	From 15/01/2024	Member of the Board	1 out of 1	

Name	Position and Area of Expertise	Dates (if not full year)	Board Committee Membership	Attendance	Champion Role
Executive Directors					
Nicola Prygodzicz	Chief Executive		Member of the Board	6 out of 6	
			Member, Charitable Funds Committee	4 out of 4	
			Attendee as requested at all Board Committees		
Rob Holcombe	Director of Finance and Procurement		Member of the Board	6 out of 6	
			Member, Charitable Funds Committee	4 out of 4	
			Required Attendee: Audit, Finance and Risk Committee		
			Attendee as requested at all Board Committees		
Dr James Calvert	Medical Director/Deputy Chief Executive	From 24/09/2023	Member of the Board	4 out of 6	Caldicott
			Required attendee: Patient Quality, Safety and Outcomes Committee		
			Attendee as requested at all Board Committees		
Sarah Simmonds	Director of Workforce and OD		Member of the Board	6 out of 6	Raising Concerns Welsh Language
			Required attendee: People and Culture Committee		
			Attendee as requested at all Board Committees		
Hannah Evans	Director of Strategy, Planning and Partnerships		Member of the Board	6 out of 6	Emergency Planning
			Required Attendee: Partnerships, Population Health and Planning Committee		
			Attendee as requested at all Board Committees		

Name	Position and Area of Expertise	Dates (if not full year)	Board Committee Membership	Attendance	Champion Role
Jennifer Winslade	Director of Nursing		Member of the Board	6 out of 6	
			Required attendee: Patient Quality, Safety and Outcomes Committee		
			Attendee as requested at all Board Committees		
Peter Carr	Director of Therapies and Health Sciences		Member of the Board	6 out of 6	Fire Safety Violence and Aggression
			Required attendee: Patient Quality, Safety and Outcomes Committee		
			Attendee as requested at all Board Committees		
Tracy Daszkiewicz	Director of Public Health		Member of the Board	5 out of 6	
			Required Attendee: Partnerships, Population Health and Planning Committee		
			Attendee as requested at all Board Committees		
Leanne Watkins	Chief Operating Officer	From 1/05/2023	Member of the Board	5 out of 6	
			Required attendee: Mental Health Act Monitoring Committee		
			Attendee as requested at all Board Committees		
Directors in Attendance					
Paul Solloway	Director of Digital	From 28/06/2023	Attendee at the Board	5 out of 5	
			Required Attendee: Partnerships, Population Health and Planning Committee		
			Attendee as requested at all Board Committees		

Name	Position and Area of Expertise	Dates (if not full year)	Board Committee Membership	Attendance	Champion Role
Director of Corporate Governance					
Rani Dash	Director of Corporate Governance		Attendee at the Board	6 out of 6	
			Attendee as requested at all Board Committees		

Quoracy of Meetings

Quorate	Non-Quorate

Board	**24 May 2023**	**19 July 2023**	**27 September 2023**	**22 November 2023**	**24 January 2024**	**27 March 2024**
Patient Quality, Safety and Outcomes Committee	**25 April 2023**	**20 June 2023**	**26 July 2023**	**11 October 2023**	**13 December 2023**	**23 February 2023**
Audit, Risk and Assurance Committee	**18 April 2023**	**23 May 2023**	**18 July 2023**	**12 September 2023**	**28 November 2023**	**6 February 2024**
Charitable Funds Committee	**28 June 2023**	**9 November 2023**	**22 January 2024**	**7 March 2024**		
Partnerships, Population Health and Planning Committee	**17 May 2023**	**12 July 2023**	**1 November 2023**	**31 January 2024**		
Mental Health Act Monitoring Committee	**19 June 2023**	**5 September 2023**	**6 December 2023**	**21 February 2023**		
Finance and Performance Committee	**21 June 2023**	**7 September 2023**	**21 December 2023**	**14 March 2024**		
People and Culture Committee	**13 June 2023**	**19 October 2023**	**22 February 2024**			
Remuneration and Terms of Service Committee	**26 April 2023**	**5 October 2023**	**17 January 2024**			

Attachment Two

Welsh Health Circulars – this will continue to be updated for final document

Date Issued	Name & No. of WHC	Progress	Rating
06/04/2023	**WHC/2023/009** COVID-19 vaccination of children aged 6 months to 4 years in a clinical risk group	Implemented as required locally - Currently a national issue with DHCW who are yet to identify eligible patients	**In Progress**
27/04/2023	**WHC/2023/11** Guidance on Self-harm: assessment, management and preventing recurrence	All GP practices in ABUHB made aware of the NICE guidance. The key recommendations associated with safeguarding, consent and confidentiality are part of the wider contractual Clinical Governance Toolkit and revalidation requirements of practitioners. All departments within MH&LD are aware of the NICE Guidelines, with information distributed for awareness through different methods within each department.	**In Progress**
09/06/2023	**WHC/2023/019** In support of prevention of suicide and self harm: GMC and NICE Guidance on Information disclosure for the protection of patients and others	This was issued via the All Wales Alert system on 9th June 2023 and cascaded to: GP Practice Managers, GP OOHs, Sessional GPs, HB Primary Care Managers, Medial Committees, Independent Hospitals / Hospices / Prisons	**Complete**
25/09/2023	**WHC/2023/008** SaBTO FAIR III recommendations to tissue and cell donation process	The tissue donation consent process is handled by NHSBT. The referral forms used by ABUHB do not ask any questions relating to consent that are impacted by the FAIR III recommendations. The ABUHB forms are predominantly an initial screening referral tool that then allows NHSBT to contact patient's families and proceed with the formal consent process.	**Complete**
03/11/2023	**WHC/2023/035** Update of guidance on clearance and management of healthcare workers living with a bloodborne virus (BBV) and a reminder of health clearance for tuberculosis		**In Progress**
09/11/2023	**WHC/2023/040** The NHS Wales: Newborn and Infant Physical Examination Cymru (NIPEC)	• Relevant staff have attended webinar • Lead staff identified to support and take forward • Review of ABUHB guideline to incorporate standards • New digital system flags NIPE check within 72 hours	**In Progress**
27/11/2023	**WHC/2023/039** Independent Authorisation of Blood Component Transfusion (IABT)	The WHC has been discussed by the Hospital Transfusion Committee (HTC). The Health Board's current policy and standard operating procedures for prescribing blood are to be reviewed in light of the WHC. The Health Board employs several non-medic BCT Authorisers who have undertaken the appropriate Wales training and compliance assessment. Each BCT Authoriser has a Consultant mentor, retains a	**In Progress**

Date Issued	Name & No. of WHC	Progress	Rating
		portfolio of practice and is regularly assessed to ensure that their practice is up to date and meets the correct standards.	
09/11/2023	**WHC/2023/038** Healthy Start eLearning Course	Course live on ESR	**Complete**
11/12/2023	**WHC/2023/044** Influenza (flu) Vaccination Programme deployment 'mop up' 2023-2024	Implemented in January 2024 as required. Borough pop-up clinics targeted 25% of GP practices with lowest flu vaccine uptake.	**Complete**
13/12/2023	**WHC/2023/046** All-Wales Control Framework for Flexible Workforce Capacity	Actions in place for phase 1 and reported to WG	**Complete**
14/12/2023	**WHC/2023/043** Vaccination of Healthcare Staff to Protect Against Measles	A task and finish group was set up on 15/12/23 in response to the WHC published on 14/12/23. The health board assessed and agreed staff high risk areas and staff MMR immunisation status was obtained via OH records and by request via WIS with staff consent. All staff who have not received a full 2 doses of MMR have been invited for an immunisation via text, email and targeted communications. Clinics have been mobilised at various locations for easy access and occupational health continue to provide weekly drop in sessions. The WHC was reinforced with primary care providers detailing steps to be taken to ensure that staff who are not fully vaccinated should make an appointment for their MMR.	**In progress**
21/12/2023	**WHC/2023/047** Influenza vaccines and eligible cohorts for the 2024 to 2025 season	Incorporated into plan development for 2024/25 season. Vaccine stock ordered in accordance with eligible cohorts and vaccine advice as per JCV	**In progress**
08/01/2024	**WHC/2023/048** Health Board allocations for 2024 to 2025	Implemented	**Complete**
11/01/2024	**WHC/2023/041** Refresh of the rare disease action plan 2022 to 2026	The Health Board recognises the actions required and has identified there are 5 specific actions that involve the Health Board and which have been acted upon.	**In progress**
20/02/2024	**WHC/2023/045** Recording dementia read codes	Dementia alerts are promoted on WPAS, so that we can see how patients with dementia are in the hospital at any given time. Dementia alerts is separate to dementia read code. These alerts will help us to improve our identification and awareness, hence we can incorporate dementia care plans	**In progress**

Date Issued	Name & No. of WHC	Progress	Rating
		as well. This will also help us with the National Audit of Dementia, which recommend us to identify those are at risk of harm in the hospital like inpatient fall but more importantly involve patient in the discharge process	
10/01/2024	**WHC/2024/001** Changes to the way individuals who are at highest risk from Covid-19 access lateral flow tests	Implemented as planned. Citizens being advised during antiviral triage on how to obtain tests from local pharmacies. Information also disseminated via ABUHB Social Media channels. Care homes informed of change to access – can still be used to expedite access to antiviral treatment. Local pharmacies participating in scheme supported by PCCS Pharmacy Advisor.	**Complete**
01/02/2024	**WHC/2024/005** Private obesity surgery and the Welsh NHS	The WHC is unclear and there remain concerns about rejection of ABUHB patients to Tier 4. Swansea Bay UHB is commissioned Tier 4 in Wales. A referral pathway has been developed for referral to SBUHB and has been provided to SBUHB for comment / agreement. The Pathway has been issued to AMD's, CD's. The Pathway and instructions have been issued to primary care. Also reviewing process and criteria at national level.	**In progress**
02/02/2024	**WHC/2024/008** Vaccination against measles - urgent action	Working group established with school nursing, vaccination service and public health. Schools identified with <90% uptake, and in-school vaccination MMR clinics planned for secondary school; community vaccine service offer for primary schools. Significant area of work to ensure data validity and rigour. Ongoing work to develop a vaccination outbreak response plan, pathways in place for rapid testing of suspected measles cases, and robust protocols in place for isolation arrangements for suspected measles cases.	**In progress**
12/02/2024	**WHC/2024/004** Assurance of aseptic preparation of medicines in NHS Wales (Sterile preparation of medicine)	Implemented as required	**Complete**
08/02/2024	**WHC/2024/009** Covid 19 spring booster vaccination programme 2024	Blended model of delivery with Primary Care and community pop-up clinics. Commenced on 2nd April in line with WHC and JCVI requirements.	**In progress**
27/02/2024	**WHC/2024/10** Welsh Sustainability Conference and Awards - New dates	Implemented as required	**Complete**
05/03/2024	**WHC/2024/02**	In progress and on track	**In progress**

Date Issued	Name & No. of WHC	Progress	Rating
	Standards for Competency Assurance of Non-Medical Prescribers in Wales		
06/03/2024	**WHC/2024/011** Changes to dietary advice on feeding young children		
19/03/2024	**WHC/2024/012** Nursing Preceptorship & Restorative Clinical Supervision - A National Position Statement		
22/03/2024	**WHC/2024/006** National Clinical Guidance for Stroke, for the UK and Ireland		
28/03/2024	**WHC/2024/017** Implementation of the Non-pay elements of the 2022-24 Collective Agreement		

Ministerial Directives

Ministerial Directive	Date Issued	Action to demonstrate implementation/response	Rating
The Duty of Candour statutory guidance 2023	01/04/2023	Currently implementing this guidance as part of the delivery of the Health Board Strategy	**In Progress**
The NHS (General Medical Services Contracts) (Wales) Regulations 2023: integrated impact assessment	11/05/2023	The Unified Contract came into effect on 1st October 2023. Health Boards are currently awaiting WG to issue a template variation notice and GMS regulations template:	**In Progress**
The Primary Care (E-Prescribing pilot scheme) Directions 2023	01/06/2023	The first use of the Electronic Prescription Service (EPS) in Wales is on track to take place this autumn in Rhyl, North Wales. There will be several weeks of testing in Rhyl before EPS is rolled out across Wales in a phased approach in 2024. ABHB will support this as required alongside the Digital Medicines Transformation Portfolio.	**In Progress**
NHS (General Medical Services contracts) (Wales) Regulations 2023	17/07/2023	Health Boards received the confirmed copy and CVN relating to the 2006 contract on 10th December 2023. Meeting held 6th February 2024 with HBs, WG and Legal representatives to discuss. Identified that not all contracts had received a CVNs in 2006, therefore WG/Legal agreed to provide the necessary documents for this. The HB received the documents on 7th March 2024 from WG. The HB will be issuing bilateral agreements for all contracts, which also requires a 14 day notification period. All contracts must be issued by 18th March to meet this deadline. 20 x bilateral agreements/conformed copy have been prepared (18 that had the 2006 variation and 2 that had had new contracts since 2006). As of March 2024, x 44 agreements need to be prepared - 4 will require the new version of the contract – which has not yet been issued. The HB will endeavour to meet this deadline, however it will be very challenging.	**In Progress**
The National Health Service (Wales Eye Care services)(Wales) Directions 2023	26/10/2023	Implemented and payments reflected	**Complete**
The Low Vision Service Committee (Wales) Directions 2016 (with consolidated amendments)	26/10/2023	Implemented and payments reflected	**Complete**
The Eye Health Examination Service Committee (Wales) Directions 2016 (with consolidated amendments)	26/10/2023	Implemented	**Complete**

Ministerial Directive	Date Issued	Action to demonstrate implementation/response	Rating
Statement of general ophthalmic service remuneration and fee Directions.	24/11/2023	Implemented with relevant fees applied. Indicative budget allocation will need continuous review to ensure appropriate level of funding is available for each service. Some services to be implemented.	**In progress**
Death Certification reform	14/12/2023	Issued	**Complete**
The Medical Examiners (Wales) Regulations 2024	14/12/2023	Primarily affects the function of the Medical Examiner; the HB is considered a stakeholder.	**Complete**
The Eye Health Examination Service Committee (Wales) Directions 2016 (with consolidated amendments)	05/01/2024	Implemented with delegated functions provided by Shared Services Partnership on behalf of the Health Board. Some aspects ongoing including WGOS 3 mobile providers and students.	**In Progress**
Wales Eye Care Services (Administrative List) (Wales) Directions 2024	05/01/2024	Implemented with delegated functions provided by Shared Services Partnership on behalf of the Health Board.	**Complete**
The Low Vision Service Committee (Wales) Directions 2016 (with consolidated amendments)	05/01/2024	Implemented with delegated functions provided by Shared Services Partnership on behalf of the Health Board.	**Complete**
The National Health Service (Wales Eye Care Services) (Wales)(No. 2) Directions 2024	05/01/2024	Implemented with delegated functions provided by Shared Services Partnership on behalf of the Health Board.	**Complete**
Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2024	14/02/2024	Actioned automatically by SSP - confirmation has been sought from all independent GMS contractors that 5% uplift has been applied	**Complete**
The National Health Service Joint Commissioning Committee (Wales) Directions 2024	29/02/2024	Implemented	**Complete**

Attachment Three

Corporate governance in central government departments: code of good practice 2017

Aneurin Bevan University Health Board Assessment 2023/24

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
2.1 2.2	Each organisation should have an effective board, which provides leadership for the business, helping it to operate in a business-like manner. The board should operate collectively, concentrating on advising on strategic and operational issues affecting the department's performance, as well as scrutinising and challenging departmental policies and performance, with a view to the long-term health and success of the Trust.	The Board meets in public on a bi-monthly basis. A forward work programme of Board Business is in place and approved on an annual basis. The work of the Board is guided and determined by its Standing Orders, Standing Financial Instructions and Schemes of Delegation. This provides the framework for delegation and decision making within the Health Board. The Board receives, as standing items to each meeting, finance, performance and corporate risk reports.	Comply	Board and Committee Minutes – demonstrate Scrutiny and support Audit Wales Structured Assessment 2023
2.3	The Board does not decide policy or exercise the powers of the ministers. The department's policy is decided by ministers alone on advice from officials. The board advises on the operational implications and effectiveness of policy proposals. The Board will operate according to recognised precepts of good corporate governance in business: • Leadership – articulating a clear vision for the department and giving clarity about how policy activities contribute to achieving this vision, including setting risk appetite and managing risk • Effectiveness – bringing a wide range of relevant experience to bear, including through offering rigorous challenge and scrutinising performance	The Board provides leadership and direction to the organisation and has a key role in ensuring that the organisation has sound governance arrangements in place. The Board seeks an open culture and high standards in the ways in which its work is conducted. Board Members share corporate responsibility for all decisions and undertake a key role in monitoring the performance of the organisation. Progress against the Health Board Integrated Medium Term Plan 2022-2025, which adopts a life course approach, is presented to the Board on a quarterly basis. The Health Board's Standing Orders and Standing Financial Instructions are designed to translate the statutory requirements into day to day operating practice, and, together with the adoption of a Schedule	Comply	Standing Orders and Standing Financial Instructions Audit Wales Structured Assessment 2023 IMTP Value and Behaviours Framework

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	• Accountability – promoting transparency through clear and fair reporting. • Sustainability – taking a long-term view about what the department is trying to achieve and what it is doing to get there.	of Decisions reserved to the Board of Directors; a Scheme of Decisions to Officers and Others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Health Board. These documents form the basis upon which the Health Board's governance and accountability framework is developed and, together with the adoption of the Health Board's Values and Behaviour Framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.		
2.4 3.10	The Board should meet on at least a quarterly basis; however, best practice is that boards should meet more frequently. The Board advises on five main areas: • Strategic Clarity • Commercial Sense • Talented People • Results focus • Management information	The Board meets at least six times a year and in addition holds an Annual General Meeting. Discussions, actions and decisions of all meetings of the Board and its Committees are formally recorded as minutes or action notes. The Board's role, as set out in its Standing Orders, is to: • Set the strategic direction for the organisation • Hold the organisation to account for performance and delivery • Set the tone and culture of the Board and the organisation The Board's business is therefore structured in this way and encompasses the five main areas set out in point 2.4.	Comply	Standing Orders and Standing Financial Instructions Audit Wales Structured Assessment 2023 Board and Committee Agenda and Meeting Papers
2.7	The Board also supports the accounting officer in the discharge of obligations set out in Managing Public Money for the proper conduct of business and maintenance of ethical standards.	The Board approves the Accountability Report, following scrutiny by the Audit, Risk and Assurance Committee, on an annual basis which includes the Statement by the Accountable Officer assuring the Board on the System of Internal Control.	Comply	Accountability Report

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
2.12	Where Board members have concerns, which cannot be resolved, about the running of the department or a proposed action, they should ensure that their concerns are recorded in the minutes.	Any concerns raised at Board and Committee meetings are formally recorded in the minutes. The role of the Director of Corporate Governance is responsible for ensuring these matters are effectively managed, recorded and resolved where possible.	Comply	Board and Committee Agenda and Papers Role of the Director of Corporate Governance
3.1 3.11 3.12 3.13	The Board should have a balance of skills and experience appropriate to fulfilling its responsibilities. The membership of the board should be balanced, diverse and manageable in size.	Constitution is set out in the Health Board's Establishment Orders and the Health Board abides by this composition. The Health Board's Standing Orders also outlines the composition of the Board. The Board has a range of skills and expertise. Individuals are appointed to Independent Member or Executive roles based on their particular backgrounds and specialist knowledge. All Independent Member appointments including the Chair and Vice Chair are appointed by Welsh Government and the appointment processes are managed by the Public Appointments Department of Welsh Government. The appointment panels for all Executive appointments, although organisation appointments, will have external independent assessors and Welsh Government representation. All Executive Directors are appointed to permanent NHS contracts. Independent Members are appointed for up to four years at any one time and can be re-appointed up to a maximum of eight years in the organisation. This is controlled by Welsh Government as they are Ministerial appointments.	Comply	Health Board Establishment Orders Standing Orders Board Member Induction checklist

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
		The Board is provided with a range of information including performance information at Board and Committee Meetings. The format and content of these is informed by national standards and requirements and also locally requested information. Independent Member membership on Board Committees are rotated at appropriate times to ensure there is mix and balance of experience across all meetings		
3.2	The roles and responsibilities of all board members should be defined clearly in the department's board operating framework.	The Board is constituted in accordance with the Health Board's Establishment Orders and Standing Orders	Comply	Health Board Establishment Orders Standing Orders
3.3	The Finance Director should be professionally qualified.	The Director of Finance and Procurement is professional qualified	Comply	Recruitment and appointment documentation for the Director of Finance and Procurement
3.5	Independent Members will exercise their role through influence and advice, supporting as well as challenging the executive	The Structured Assessment 2023 highlights that • *Independent Members participate fully in meetings, providing reasonably effective scrutiny on the information presented.* • *The Health Board has effective local induction arrangements for Executive Directors and Independent Members. These include meetings with other Board*	Comply	Audit Wales Structured Assessment 2023 Independent Member Induction Pack

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
		• *Members and stakeholders alongside detailed training materials. Independent members indicated they feel supported in their ongoing learning and development*. There is a national programme of induction, in which all members are asked to participate. This is organised by Academi Wales and Welsh Government. Tailored programmes of induction is in place new Independent Members, and work continues to build a comprehensive programme for future use. There is also a programme of Board Development Sessions and Board Briefings and other training made available to the Board.		
3.15	The Board should agree and document in its board operating framework a *de minimis* threshold and mechanisms for board advice on the operation and delivery of policy proposals.	A forward work programme of Board Business is in place and approved on an annual basis. The Terms of Reference Operating Arrangements for the Board Committees articulate their remit. A forward work programme for each Committee is in place and approved on an annual basis.		Board Forward Work Programme Committee Forward Work Programmes Committee Terms of Reference
4.1	The Board should ensure that arrangements are in place to enable it to discharge its responsibilities effectively, including: 1. formal procedures for the appointment of new board members, tenure and succession planning for both board members and senior officials 2. allowing sufficient time for the board to discharge its collective responsibilities effectively 3. induction on joining the board, supplemented by regular updates to keep board members' skills and knowledge up-to-date	All Independent Member appointments including the Chair and Vice Chair are appointed by Welsh Government and the appointment processes are managed by the Public Appointments Department of Welsh Government. All Executive appointments, although internal appointments have external independent assessors on the panels and also Welsh Government representation. The Director of Corporate Governance monitors the terms of office of Independent Members to ensure		Terms of Reference and Operating Arrangements for Board and Committees Board and Committee Forward Work Programmes

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	4. timely provision of information in a form and of a quality that enables the board to discharge its duties effectively 5. a mechanism for learning from past successes and failures within the departmental family and relevant external organisations 6. a formal and rigorous annual evaluation of the board's performance and that of its committees, and of individual board members 7. a dedicated secretariat with appropriate skills and experience	succession planning is timely and managed in conjunction with the public appointments unit. Agenda Setting meetings are held with the Chair, Chief Executive and Director of Corporate Governance to plan the agenda and ensure sufficient time is allocated to the right things at Board meetings. Board Induction programme in place (as previously referenced), supplemented by ongoing Board Briefing and Board Development sessions. The Chair undertakes regular one to ones and annual Personal Appraisal and Development Reviews with all Independent Members. Agenda and papers for Board meetings are published one week prior to the meeting. Report templates have been revised to ensure to support the provision of appropriate and relevant information. Revised Corporate Governance Structure implemented during 2023. Head of Board Business appointed and Improving Board Business Plan in place to develop processes to improve the effectiveness and efficiency of the Board. The Board's Quality Strategy and Quality Assurance Framework ensure learning as a key pillar of quality, embedded across the organisation. The Board undertakes an assessment of its effectiveness using the NHS England and NHS Improvement (NHSE and NHSI) Well-led Framework for		

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
		Leadership and Governance Developmental Reviews. During 2023/24, Committees undertook a mid-year self-assessment of their effectiveness to inform the Board's end of year assessment.		
4.5	The terms of reference for the nominations committee will include at least the following three central elements: • scrutinising systems for identifying and developing leadership and high potential • scrutinising plans for orderly succession of appointments to the board and of senior management, in order to maintain an appropriate balance of skills and experience • scrutinising incentives and rewards for executive board members and senior officials, and advising on the extent to which these arrangements are effective at improving performance	The Terms of Reference and operating arrangements are based on the model Standing Orders and ensure that roles and responsibilities of Board Committees capture scrutiny and assurance roles. The Chair reviews the membership of Committees on an annual basis to ensure the appropriate balance of skills and expertise and support succession planning.	Comply	Terms of Reference for Board Committees Standing Orders
4.6	The attendance record of individual board members should be disclosed in the governance statement and cover meetings of the board and its committees held in the period to which the resource accounts relate.	The Annual Governance Statement provides details on the membership of the Board and Committee and the attendance record of individuals at these meetings.	Comply	Annual Governance Statement
4.10	Where necessary, board members should seek clarification or amplification on board issues or board papers through the board secretary. The board secretary will consider how officials can best support the work of board members; this may include providing board members with direct access to officials where appropriate.	Independent Members of the Board have direct access to members of the executive team in order to seek further information or clarification on issues as and when they arise. Regular Board Development sessions and Board briefings are also held to ensure that Board members are kept up to date on the breadth of issues. The Director of Corporate Governance acts as an independent voice within the organisation to advise and support the Board on governance matters and its	Comply	Board Secretary role profile

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
		approach to openness and transparency. The Director of Corporate Governance is responsible for developing the programmes of work for the Board and Committees of the organisation. Ensuring that agenda and papers are developed and reviewed prior to publication to ensure the quality or reports and maximum transparency and openness in the way in which the organisation conducts its business.		
4.11	An effective board secretary is essential for an effective board. Under the direction of the permanent secretary, the board secretary's responsibilities should include: – developing and agreeing the agenda for board meetings with the chair and lead non-executive board member, ensuring all relevant items are brought to the board's attention – ensuring good information flows within the board and its committees and between senior management and non-executive board members, including: – challenging and ensuring the quality of board papers and board information – ensuring board papers are received by board members according to a timetable agreed by the board – providing advice and support on governance matters and helping to implement improvements in the governance structure and arrangements – ensuring the board follows due process – providing assurance to the board that the department: – complies with government policy, as set out in the code	The Director of Corporate Governance undertakes these roles as Board Secretary for the Health Board	Comply	Board Secretary role description Standing Orders

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	– adheres to the code's principles and supporting provisions on a comply or explain basis (which should form part of the report accompanying the resource accounts) – acting as the focal point for interaction between non-executive board members and the department, including arranging detailed briefing for non-executive board members and meetings between non-executive board members and officials, as requested or appropriate recording board decisions accurately and ensuring action points are followed up – arranging induction and professional development of board members (including ministers)			
4.14	Evaluations of the performance of individual board members should show whether each continues to contribute effectively and corporately and demonstrates commitment to the role (including commitment of time for board and committee meetings and other duties).	Individual annual assessment of Board Executive Directors is undertaken by the Chief Executive and Independent Members by the Chair, with the former reported to the Remuneration and Terms of Service Committee.	Comply	Appraisal documentation and process
4.15	All potential conflicts of interest for non-executive board members should be considered on a case by case basis. Where necessary, measures should be put in place to manage or resolve potential conflicts. The board should agree and document an appropriate system to record and manage conflicts and potential conflicts of interest of board members. The board should publish, in its governance statement, all relevant interests of individual board members and how any identified conflicts, and potential conflicts, of interest of board members have been managed.	Board Members complete annual Declarations of Interest and this register is available on the Health Board's website. Declarations of Interest in relation to items on the agenda are also sought at each Board and Committee meeting and are formally recorded within the minutes. Standards of Business Conduct for Employees in place and details responsibilities for declarations of interests.	Comply	Declarations of Interest Register Standards of Business Conduct for Employees Policy

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
5.1 5.8	The board should ensure that there are effective arrangements for governance, risk management and internal control for the whole departmental family. Advice about and scrutiny of key risks is a matter for the board, not a committee. The board should be supported by: – an audit and risk assurance committee, chaired by a suitably experienced non-executive board member – an internal audit service operating to Public Sector Internal Audit Standards1 – sponsor teams of the department's key ALBs	The Health Board has established an Audit, Risk and Assurance Committee, chaired by the Independent Member Finance lead. NWSSP Internal Audit Services are appointed as the Health Boards Internal Auditors The Health Board and its Committees monitor the management of risk considering the risks profile and actively engaging in its management.	Comply	Terms of Reference and Operating Arrangements for the Audit, Risk and Assurance Committee Accountability Report Audit Wales Structured Assessment
5.2 5.13	The board should take the lead on, and oversee the preparation of, the department's governance statement for publication with its resource accounts each year. The annual governance statement (which includes areas formerly covered by the statement on internal control) is published with the resource accounts each year. In preparing it, the board should assess the risks facing the department and ensure that the department's risk management and internal control systems are effective. The audit and risk assurance committee should normally lead this assessment for the board.	The Audit, Risk and Assurance Committee is responsible for reviewing the system of governance and assurance established within the Health Board and the arrangements for internal control, including risk management for the organisation and, in particular, advises on the Annual Governance Statement signed by the Chief Executive. The Governance Statement is included within the Accountability Report which is considered by the Audit, Risk and Assurance Committee prior to approval by the Board.	Comply	Accountability Report
5.3 5.10	The board's regular agenda should include scrutinising and advising on risk management.	The Health Board approve the Risk Management Strategy and Board Assurance Framework. The Health Board and its Committees monitor the management of risk considering the risks profile and actively engaging in its management.		Board and Committee Agendas and papers Risk Management Strategy

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
		A Corporate Risk Register is maintained and considered at each Board Meeting, and by the Audit, Risk and Assurance Committee. Each Committee monitors risks associated with its portfolio and provides assurance reports on these to the Board.		Board Assurance Framework Corporate Risk Register
5.4 5.9 5.11 5.12 5.14 5.15	The key responsibilities of non-executive board members include forming an audit and risk assurance committee. The board and accounting officer should be supported by an audit and risk assurance committee, comprising at least three members. An audit and risk assurance committee should not have any executive responsibilities or be charged with making or endorsing any decisions. It should take care to maintain its independence. The audit and risk assurance committee should be established and function in accordance with the *Audit and risk assurance committee handbook.* The board should ensure that there is adequate support for the audit and risk assurance committee, including a secretariat function. The terms of reference of the audit and risk assurance committee, including its role and the authority delegated to it by the board, should be made available publicly. The department should report annually on the work of the committee in discharging those responsibilities	An Audit, Risk and Assurance Committee is established. The Terms of Reference and Operating Arrangements for the ARA Committee are clear in relation to authority and delegated responsibilities. These Terms of Reference are published on the Health Board's website. Full secretariat support is provided by the Corporate Governance Team. 5 Independent Members comprise the Audit, Risk and Assurance Committee. The Board Assurance Framework is scrutinised by the Audit, Risk and Assurance Committee.	Comply	Terms of Reference and Operating Arrangements for Audit, Risk and Assurance Committee Board Assurance Framework

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	Boards should ensure the scrutiny of governance arrangements, whether at the board or at one of its subcommittees (such as the audit and risk assurance committee or a nominations committee). This will include advising on, and scrutinising the department's implementation of, corporate governance policy.			
5.5	The head of internal audit should periodically be invited to attend board meetings, where key issues are discussed relating to governance, risk management processes or controls across the department and its ALBs.	The role of Head of Internal Audit is clearly set out in the Health Board's Standing Orders. The Head of Internal Audit attends all meetings of the Audit, Risk and Assurance Committee. Audit Wales and Internal Audit have a routine invite to all Board and Committee meetings.	Comply	Standing Orders Terms of Reference for the Audit, Risk and Assurance Committee
5.6 5.7 5.10	The board should assure itself of the effectiveness of the department's risk management system and procedures and its internal controls. The board should give a clear steer on the desired risk appetite for the department and ensure that: • there is a proper framework of prudent and effective controls, so that risks can be assessed, managed and taken prudently • there is clear accountability for managing risks • Departmental officials are equipped with the relevant skills and guidance to perform their assigned roles effectively and efficiently. The board should also ensure that the department's ALBs have appropriate and effective risk management processes through the department's sponsor teams	The Health Board has an agreed Risk Management Strategy. Development work continues to review and refine the Risk Management Strategy, with a Board Development session held in March 2022 focused on strategic risk management and assurance arrangements, including risk appetite and tolerance which will be a key element of the updated Risk Management Strategy. The Risk Management Strategy articulates a clear risk escalation pathway. A Risk Management Community of Practice is in place, led by the Head of Corporate Services, Risk and Assurance.	Comply	Risk Management Strategy Corporate Risk Register

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	Advising on key risks is a role for the board. The audit and risk assurance committee should support the board in this role.			

Remuneration and Staff Report 2023/24

The Treasury's Government Financial Reporting Manual (FReM) requires that a Remuneration Report shall be prepared by NHS bodies providing information under the headings in SI 2008 No 410, made to the extent that they are relevant. The Remuneration Report contains information about senior managers remuneration. The definition of 'Senior Manager' is: "those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments."

This section of the Accountability Report meets these requirements.

The Remuneration and Terms of Service Committee

Remuneration and Terms of Service for Executive Directors and the Chief Executive are agreed, and kept under review, by the Board's Remuneration and Terms of Service Committee. The Committee also monitors and evaluates the annual performance of the Chief Executive and individual Directors (the latter with the advice of the Chief Executive). In 2023/24, the Remuneration and Terms of Service Committee was chaired by the Health Board's Chair, Ann Lloyd CBE, and the membership included the following Members:

- Pippa Britton, Vice Chair of the Board;
- Iwan Jones, Chair of Audit, Risk and Assurance Committee
- Louise Wright, Independent Member (Trade Union).

Meetings are minuted and decisions fully recorded.

Independent Member Remuneration

Remuneration for Independent Members is determined by the Welsh Government, along with the tenure of appointments. Details of Independent Members' remuneration for the 2023/24 financial year, together with comparators are given in Tables below.

Directors' Remuneration

Details of Directors' remuneration for the 2023/24 financial year, together with comparators are given in Tables below. The norm is for Executive Directors and Senior Managers salaries to be uplifted in accordance with the Welsh Government identified normal pay inflation percentage. In 2023/24, Executive Directors received a pay inflation uplift, in-line with Welsh Government's Framework.

The Remuneration and Terms of Service Committee also reviews objectives set for Executive Directors and assesses performance against those objectives when considering recommendations in respect of annual pay uplifts. It should be noted that Executive Directors are not on any form of performance related pay. All contracts are permanent with a three-month

notice period. Conditions are in line with those set by Welsh Government as part of the NHS Reform Programme of 2009.

The Remuneration and Terms of Service Committee considers issues of equality and diversity when evaluating and setting remuneration for Directors', particularly in relation to gender and ethnicity in pay levels, in line with Welsh Government's Framework.

Salary and Pension Disclosure Table: Salaries and Allowances

Salary and Pension entitlements of Senior Managers Remuneration

		2023-24					2022-23				
Name	**Title**	**Full Year Equivalent Salary (bands of £5,000)**	**Salary (bands of £5,000)**	**Benefits in kind (to nearest £100)**	**Pension Benefits**	**Total (bands of £5,000)**	**Full Year Equivalent Salary (bands of £5,000)**	**Salary (bands of £5,000)**	**Benefits in kind (to nearest £100)**	**Pension Benefits**	**Total (bands of £5,000)**
		£000	**£000**	**£00**	**£000**	**£000**	**£000**	**£000**	**£00**	**£000**	**£000**
Executive Directors											
Glyn Jones	Deputy Chief Executive (From 05.09.22 Until 23.09.22) / Interim Chief Executive (From 01.11.21 Until 04.09.22)						205 - 210	100 - 105	0	32	135 - 140
Nicola Prygodzicz	Chief Executive (From 05.09.22)	225 - 230	205 - 210	12	62	270 - 275	215 - 220	165 - 170	12	282	450 - 455
	Director of Planning, Performance, Digital & IT / Interim Deputy Chief Executive (Until 04.09.22)						125 - 130				
Dr James Calvert	Medical Director / Deputy Chief Executive (From 24.09.22)	205 - 210	215 - 220	0	57	275 - 280	190 - 195	195 - 200	0	66	260 - 265
	Medical Director (Until 23.09.22)						185 - 190				
Robert Holcombe	Director of Finance and Procurement (From 14.11.22)	160 - 165	160 - 165	0	0	160 - 165	150 - 155	155 - 160	0	200	355 - 360
	Interim Director of Finance, Procurement and Value Based Healthcare (Until 13.11.22)						150 - 155				
Chris Dawson-Morris	Interim Director of Planning and Performance (From 05.09.22 Until 02.04.23)	125 - 130	0 - 5	0	0	0 - 5	125 - 130	75 - 80	0	15	90 - 95
Hannah Evans	Director of Strategy, Planning and Partnerships (From 01.04.23)	145 - 150	145 - 150	0	82	230 - 235					
Jennifer Winslade	Director of Nursing (From 08.08.22)	145 - 150	145 - 150	7	0	150 - 155	135 - 140	90 - 95	0	59	150 - 155
Linda Alexander	Director of Nursing (From 25.06.22 Until 14.08.22)							15 - 20	0	10	25 - 30
Rhiannon Jones	Director of Nursing (Until 05.07.22)							35 - 40	0	7	40 - 45
Sarah Simmonds	Director of Workforce and Organisational Development	145 - 150	150 - 155	15	51	200 - 205	140 - 145	140 - 145	15	72	215 - 220
Dr Sarah Aitken	Director of Public Health and Strategic Partnerships (Until 05.01.23)						130 - 135	95 - 100	0	0	95 - 100
Peter Carr	Director of Therapies and Health Sciences	115 - 120	120 - 125	0	0	120 125	110 - 115	110 - 115	25	16	130 - 135
Dr Chris O'Connor	Interim Director of Primary, Community and Mental Health Services (Until 30.04.23)	130 - 135	10 - 15	0	0	10 - 15	145 - 150	145 - 150	0	212	360 - 365
Tracy Daszkiewicz	Director of Public Health and Strategic Partnerships (From 01.04.23)	140 - 145	140 - 145	0	35	175 - 180					
Chief Operating Officer											
Leanne Watkins	Chief Operating Officer (From 01.05.23) / Director of Operations (From 17.03.22 Until 30.04.23)	145 - 150	150 - 155	17	121	270 - 275	120 - 125	120 - 125	17	32	155 - 160
Other Directors											
Rani Dash	Director of Corporate Governance	120 - 125	125 - 130	45	64	195 - 200	110 - 115	110 - 115	56	41	155 - 160
Paul Solloway	Director of Digital (From 28.06.23)	125 - 130	90 - 95	6	214	305 - 310					

Special Advisor to the Board

Philip Robson	Special Advisor to the Board	15 - 20	15 - 20	0	0	15 - 20	15 - 20	15 - 20	0	0	15 - 20

Independent Members

Ann Lloyd CBE	Chair	65 - 70	65 - 70	0	0	65 - 70	65 - 70	65 - 70	0	0	65 - 70
Pippa Britton	Vice Chair (Interim Until 02.05.23)	55 - 60	55 - 60	0	0	55 - 60	55 - 60	55 - 60	0	0	55 - 60
Katija Dew	Independent Member (Third/Voluntary Sector) (Until 31.03.23)						15 - 20	15 - 20	0	0	15 - 20
Martin Blakebrough	Independent Member (Third Sector) (From 03.05.23)	15 - 20	0 - 5	0	0	0 - 5					
Prof. Helen Sweetland	Independent Member (University)	0	0	0	0	0	0	0	0	0	0
Richard Clark	Independent Member (Local Authority)	15 - 20	15 - 20	0	0	15 - 20	15 - 20	15 - 20	0	0	15 - 20
Paul Deneen	Independent Member (Community)	15 - 20	15 - 20	0	0	15 - 20	15 - 20	15 - 20	0	0	15 - 20
Shelley Bosson	Independent Member (Community)	15 - 20	15 - 20	0	0	15 - 20	15 - 20	15 - 20	0	0	15 - 20
Penny Jones	Independent Member (Community) (From 15.01.24)	15 - 20	15 - 20	0	0	15 - 20					
Dafydd Vaughan	Independent Member (Digital) (From 09.05.22)	15 - 20	15 - 20	0	0	15 - 20	15 - 20	10 - 15	0	0	10 - 15
Iwan Jones	Independent Member (Finance) (From 04.04.22)	15 - 20	15 - 20	0	0	15 - 20	15 - 20	15 - 20	0	0	15 - 20
Louise Wright	Independent Member (Trade Union)	0	0	0	0	0	0	0	0	0	0
Keith Sutcliffe	Associate Independent Member (Chair of Stakeholder Group) (Until 30.11.22)						0	0	0	0	0

	2023-24	
	Pay	Ratio
Band of Highest paid Director's Total Remuneration £000	225 - 230	
25th percentile pay £	28,581	8.0
Median pay £	35,922	6.3
75th percentile pay £	46,686	4.9

2022-23	
Pay	Ratio
215 - 220	
26,282	8.3
33,428	6.5
43,078	5.0

Salary has been reported as gross pay, which is before the deduction of any salary sacrifice schemes. During 2023-24 the following salary was sacrificed.

	Lease Car Scheme	Home Electronics Scheme
	£'000	£'000
Nicola Prygodzicz	7	
Jennifer Winslade	6	
Sarah Simmonds	8	
Leanne Watkins	11	<1
Rani Dash	7	
Paul Solloway	6	

The post of Special Advisor to the Board has been disclosed as it has been deemed to have an influence over board decisions.

Martin Blakebrough commenced with the Health Board on 3rd May 2023 but has yet to formally take up Board duties.

The amount of pension benefits for the year which contributes to the single total figure is calculated using a similar method to that used to derive pension values for tax purposes and is based on information received from NHS BSA Pensions Agency.

The value of pension benefits is calculated as follows:
(real increase in pension* x20) + (real increase in any lump sum) – (contributions made by member)
*excluding increases due to inflation or any increase of decrease due to a transfer of pension rights

This is not an amount which has been paid to an individual by the Health Board during the year, it is a calculation which uses information from the pension benefit table. These figures can be influenced by many factors e.g. changes in a persons salary, whether or not they choose to make additional contributions to the pension scheme from their pay and other valuation factors affecting the pension scheme as a whole.

Robert Holcombe, Jennifer Winslade, Peter Carr and Dr Chris O'Connor are affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.

Due to the deadline for requests of pension entitlements issued by NHS Business Services Authority the reported pension benefits exclude the affect of the revised salary applied in March 2024.

During 2023-24 the Health Board has paid two former chief executives who were on secondment to Welsh Government. Andrew Goodall has been seconded since 8th June 2014 and Judith Paget had been seconded since 1st November 2021 until 30th November 2024. The details of the remuneration received by these individuals is disclosed in the accounts of the Welsh Government, and the Health Board was reimbursed for the employment costs incurred. The salary for Andrew Goodall was between £230,000 to £235,000 (£215,000 to £220,000 2022-23) and for Judith Paget between £155,000 to £160,000 (£215,000 to £220,000 2022-23).

Salary and Pension entitlements of Senior Managers Pension Benefits

Name	Title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2024 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2024 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2024 £000	Cash Equivalent Transfer Value at 31 March 2023 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £00
Nicola Prygodzicz	Chief Executive	0.0 - 2.5	47.5 - 50.0	70 - 75	195 - 200	1650	1175	328	0
Dr James Calvert	Medical Director / Deputy Chief Executive	0.0 - 2.5	45.0 - 47.5	85 - 90	235 - 240	2114	1589	337	0
Robert Holcombe	Director of Finance and Procurement	(2.5) - 0.0	32.5 - 35.0	55 - 60	145 - 150	1290	965	206	0
Chris Dawson-Morris	Interim Director of Planning and Performance (Until 02.04.23)	0.0 - 2.5	0.0	10 - 15	0	133	78	0	0
Hannah Evans	Director of Strategy, Planning and Partnerships (From 01.04.23)	2.5 - 5.0	42.5 - 45.0	40 - 45	105 - 110	846	527	246	0
Jennifer Winslade	Director of Nursing	(7.5) - (5.0)	25.0 - 27.5	55 - 60	150 - 155	1316	1088	98	0
Sarah Simmonds	Director of Workforce and Organisational Development	0.0 - 2.5	30.0 - 32.5	35 - 40	90 - 95	736	479	190	0
Peter Carr	Director of Therapies and Health Sciences	(7.5) - (5.0)	17.5 - 20.0	40 - 45	110 - 115	937	753	91	0
Dr Chris O'Connor	Interim Director of Primary, Community and Mental Health Services (Until 30.04.23)	(2.5) - 0.0	0.0 - 2.5	45 - 50	115 - 120	993	909	(2)	0
Tracy Daszkiewicz	Director of Public Health and Strategic Partnerships (From 01.04.23)	2.5 - 5.0	0.0	15 - 20	0	224	166	22	0
Leanne Watkins	Chief Operating Officer (From 01.05.23) / Director of Operations (Until 30.04.23)	2.5 - 5.0	45.0 - 47.5	50 - 55	135 - 140	1061	671	304	0
Rani Dash	Director of Corporate Governance	0.0 - 2.5	30.0 - 32.5	25 - 30	70 - 75	517	299	172	0
Paul Solloway	Director of Digital (From 28.06.23)	10.0 - 12.5	25.0 - 27.5	35 - 40	100 - 105	809	471	209	0

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

Due to the deadline for requests of pension entitlements issued by NHS Business Services Authority the reported pension entitlements exclude the affect of the revised pay applied in March 2024.

Pensions tax annual allowance – Scheme Pays arrangements 2019/20

In accordance with a Ministerial Direction issued on 18 December 2019, the Welsh Government have taken action to support circumstances where pensions tax rules are impacting upon clinical staff who want to work additional hours, and have determined that:

- clinical staff who are members of the NHS Pension Scheme and who, as a result of work undertaken in the 2019-20 tax year, face a tax charge on the growth of their NHS pension benefits, may opt to have this charge paid by the NHS Pension Scheme, with their pension reduced on retirement.

Welsh Government, on behalf of the Aneurin Bevan University Health Board, will pay the members who opt for reimbursement of their pension, a corresponding amount on retirement, ensuring that they are fully compensated for the effect of the deduction.

This scheme will be funded directly by the Welsh Government to the NHS Business Services Authority Pension Division, the administrators on behalf of the Welsh claimants.

Clinical staff have until 31 March 2022 to opt for this scheme and the ability to make changes up to 31 July 2026

The Health Board have included a Scheme Pay provision of £604,453 (as notified by Welsh Government) within these accounts.

Remuneration Relationship

9.6 Fair Pay disclosures								
9.6.1 Remuneration Relationship								
Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/employee in their organisation and the 25th percentile, median and 75th percentile remuneration of the organisation's workforce.								
		2023-24	**2023-24**	**2023-24**		2022-23	2022-23	2022-23
		£000	**£000**	**£000**		£000	£000	£000
Total pay and benefits		**Chief Executive**	**Employee**	**Ratio**		Chief Executive	Employee	Ratio
	25th percentile pay ratio	**225 - 230**	**29**	**8.0**		215 - 220	26	8.3
	Median pay	**225 - 230**	**36**	**6.3**		215 - 220	33	6.5
	75th percentile pay ratio	**225 - 230**	**47**	**4.9**		215 - 220	43	5.0
Salary component of total pay and benefits								
	25th percentile pay ratio	**225 - 230**	**29**			215 - 220	26	
	Median pay	**225 - 230**	**36**			215 - 220	33	
	75th percentile pay ratio	**225 - 230**	**47**			215 - 220	43	
Total pay and benefits		**Highest Paid Director**	**Employee**	**Ratio**		Highest Paid Director	Employee	Ratio
	25th percentile pay ratio	**225 - 230**	**29**	**8.0**		215 - 220	26	8.3
	Median pay	**225 - 230**	**36**	**6.3**		215 - 220	33	6.5
	75th percentile pay ratio	**225 - 230**	**47**	**4.9**		215 - 220	43	5.0
Salary component of total pay and benefits								
	25th percentile pay ratio	**225 - 230**	**29**			215 - 220	26	
	Median pay	**225 - 230**	**36**			215 - 220	33	
	75th percentile pay ratio	**225 - 230**	**47**			215 - 220	43	

In 2023-24, 10 (2022-23, 15) employees received remuneration in excess of the highest-paid director.

Remuneration for all staff ranged from £15k to £383k (2022-23, £14k to £416k).

The all staff range includes directors (including the highest paid director) and excludes pension benefits of all employees.

Financial year summary

There has been a decrease in the pay ratio which attributable to the increase in the chief executive / highest paid director salary being less than the increase in the employee median salary.

The median pay ratio for the relevant financial year is consistent with the pay, reward and progression policies for the entity's employees taken as a whole.

9.6.2 Percentage Changes	2022-23 to 2023-24	2021-22 to 2022-23
% Change from previous financial year in respect of Chief Executive	%	%
Salary and allowances	5	7
Performance pay and bonuses	0	0
% Change from previous financial year in respect of highest paid director		
Salary and allowances	5	7
Performance pay and bonuses	0	0
Average % Change from previous financial year in respect of employees takes as a whole		
Salary and allowances	7	5
Performance pay and bonuses	0	0

STAFF REPORT

Staff Numbers

9.2 Average number of employees	Permanent Staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Collaborative Bank Staff	Other	Total	2022-23
	Number	Number	Number	Number	Number	Number	Number	Number
Administrative, clerical and boarc	2,743	12	6	0	0	0	2,761	2,727
Medical and dental	839	8	73	404	0	14	1,338	1,259
Nursing, midwifery registered	3,815	1	196	0	0	0	4,012	3,991
Professional, Scientific, and tech	449	0	3	0	0	0	452	462
Additional Clinical Services	2,804	0	37	0	0	0	2,841	2,877
Allied Health Professions	857	0	19	0	0	0	876	829
Healthcare Scientists	242	0	5	0	0	0	247	245
Estates and Ancilliary	995	0	98	0	0	0	1,093	1,146
Students	9	0	0	0	0	0	9	10
Total	12,753	21	437	404	0	14	13,629	13,546

The data above represents an average over 52 weeks of the year and includes agency workers and specialist trainees. There has been a small increase in staff in post overall. The strategic work to reduce agency over the past 12 months has been successful along with increases in most clinical roles.

Turnover has reduced from the previous year to the pre-pandemic rates of 9.1%.

Staff Composition

The table below provides the breakdown of staff numbers per discipline and professional group within the Health Board.

The gender breakdown for all staff groups as at 31 March 2024 is provided below:

	2023-2024			2022-2023			2021-2022		
	Directors	**WTE**		**Directors**	**WTE**	**%**	**Directors**	**WTE**	**%**
Female	8	10,413	79.60%	5	10,127	80.06%	4.78	9722.1	79.27%
Male	4	2669	20.40%	6	2521.5	19.94%	6	2543.1	20.73%
Total	**12**	**13,082.00**		**11**	**12,648.50**		**10.78**	**12,265.20**	

The total number of staff per discipline will differ from the staff numbers shown in the gender breakdown table as the gender figures are based on a point in time as of 31 March 2024 whereas the staff per discipline numbers represent the average over a 52 week period of staff in post.

Sickness Absence Data

The Health Board's sickness absence rate for 2023/2024 is 6.10%, a decrease in sickness related absence from 6.74% in 2022/2023 which was a reduction in the previous year of 6.30% in 2021/2022. Sickness absence remained above 6% from August 2023 to February 2024 reducing to 5.9%, in March 2024. January 2024 recorded the highest sickness absence at 6.79%.

The table below provides the sickness absence trend data for the Health Board over the last nine years.

Sickness Absence	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Days Lost (Short Term <28 days)	61261	53097	60406	54759	68229	60411	79761	98573	85948
Days Lost (Long Term >28 days)	144562	147711	153345	162684	194289	188778	203781	205131	207218
Total Days Lost	205823	200808	213751	217443	262518	249189	283542	303704	293166
Total Staff Years	902	880	937	954	1156	1093	1249	1350	1308
Average Working Days Lost	14.7	14.2	15.2	15.2	15.2	16	17.2	18	17.5
Total staff employed in period (headcount)	14020	14155	10412	14334	14835	15528	15863	16245	16735
Total staff employed with no absence (headcount)	4919	5803	4848	5016	5402	6055	5710	5035	5188
Percentage staff with no sick	40%	41%	37%	35%	36%	39%	36%	31%	31%

Over the past 9 years, the average working days lost per individual has increased slightly year on year, however in 2023/24 average sickness days lost has reduced to 17.5 days per individual employee.

Staff Policies

Aneurin Bevan University Health Board has a robust framework of Policies and Procedures to enable appropriate action in order to discharge its statutory requirements and appropriate accountability for:

- Giving full and fair consideration to applications for employment made by disabled persons or other protected characteristics, having regard to their particular aptitudes and abilities;
- Continuing the employment of and for arranging appropriate training for employees, who have become disabled persons during the period when they were employed by the company;
- Otherwise for the training, career development and promotion of staff with protected characteristics persons employed by the Health Board.

Staff policies applied during the reporting period 1 April 2023 to 31 March 2024 include:

- Employment of Disabled People
- Equality and Diversity Policy
- NHS Wales Managing Attendance at Work Policy
- NHS Wales Respect and Resolution Policy
- Speaking Up Safely Framework

All policies are developed in partnership with staff and trade union colleagues and are assessed via an Equality Impact Assessment to ensure

that every policy are fair and do not present barriers to participation or disadvantage any protected groups from participation.

Employee Relations Matters

Details of the number of disciplinary cases between 1 April 2023 to 31 March 2024 is provided below:

Disciplinary Cases	Dismissals	Appeals	Employment Tribunals	Upholding Professional Standards in Wales
63	2	2	3	9

The above activity demonstrates a 72% reduction in disciplinary cases since launching the avoidable employee harm work programme in 2021/22. The purpose of the avoidable employee harm programme is to find other mechanisms to consider allegations of minor misconduct or unintended errors made by the workforce (e.g. reflective practice, training)

Payment to Past Directors

No payments have been made to any person who was not a director at the time the payment was made, but who had been a director of the Health Board previously.

Expenditure on Consultancy

Sum of GL Balance			
Txn Name/Pay WTE	**C Level**	**Description**	**Total**
ATTAIN HEALTH MANAGEMENT SERVICES LTD	**CPLN: Director of Planning**	RPB - Strategic Capital Consultancy review of Services	101,935
CGI IT UK LTD	**CDDS: Digital, Data & Technology**	G CLOUD Consultancy - Workstream Business Case consultation for new Clinical Portal	93,767
DALTON CONSULTING	**CCEO: Chief Exec/Non Execs**	Advisory Support to Exec Team	4,150
ERNST & YOUNG LLP	**CFIN: Finance Director**	VAT Consultancy & Advisory Services	102,466
HUGH IRWIN ASSOCIATES LTD	**CPLN: Director of Planning**	RPB - Strategic Capital Consultancy review of Services	1,600
OXFORD BROOKES ENTERPRISES LTD	**CPLN: Director of Planning**	RPB - Strategic Capital Consultancy review of Services	14,110
SIRIUS PARTNERS	**CPLN: Director of Planning**	RPB - Strategic Capital Consultancy review of Services	16,338
SUPPORTIVE CARE UK LTD	**CLPC: Primary Care & Community Services**	Consultant Support to the Specialist Palliative Care Service	76,050
SYNBIOTIX SOLUTIONS LTD	**CNON: Estates and Facilities Division**	VAT reclaim from Catering Consultancy Invoice from 22/23	-131
Grand Total			**410,285**

Tax Assurance for Off-payroll Engagements

Table 1 : For all off-Payroll engagements as of 31 March 2024, for more than £245 per day

No. of exisiting Engagements as of 31 March 2024	3
Of which, the number that have existed:	
for less than one year at time of reporting	1
for between one and two years at time of reporting	0
for between two and three years at time of reporting	0
for between three and four years at time of reporting	0
for four or more years at time of reporting	2

Annex 1 (Continued)Table 2: All highly paid off-payroll workers engaged at any point during the year ended 31 March 2024, earning £245 per day or greater

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	
Number of individuals that have been deemed " board members, and/or, senior officials with significant financial responsibility" , during the financial year. This figure should include both off-payroll and on-payroll engagements.	10

Exit Packages and Severance Payments

9.5 Reporting of other compensation schemes - exit packages					
	2023-24	2023-24	2023-24	2023-24	2022-23
Exit packages cost band (including any special payment element)	**Number of compulsory redundancies**	**Number of other departures**	**Total number of exit packages**	**Number of departures where special payments have been made**	Total number of exit packages
	Whole numbers only	**Whole numbers only**	**Whole numbers only**	**Whole numbers only**	Whole numbers only
less than £10,000	0	0	0	0	0
£10,000 to £25,000	0	0	0	0	0
£25,000 to £50,000	0	0	0	0	1
£50,000 to £100,000	0	0	0	0	0
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	0	0	0	1

	2023-24	2023-24	2023-24	2023-24	2022-23
Exit packages cost band (including any special payment element)	**Cost of compulsory redundancies**	**Cost of other departures**	**Total cost of exit packages**	**Cost of special element included in exit packages**	Total cost of exit packages
	£	**£**	**£**	**£**	£
less than £10,000	0	0	0	0	0
£10,000 to £25,000	0	0	0	0	0
£25,000 to £50,000	0	0	0	0	32,197
£50,000 to £100,000	0	0	0	0	0
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	0	0	0	32,197

Exit costs paid in year of departure	**Total paid in year**	Total paid in year
	2023-24	2022-23
	£	£
Exit costs paid in year	0	0
Total	0	0

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Voluntary Early Release Scheme (VERS).

Where the LHB has agreed early retirements, the additional costs are met by the LHB and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

The Health Board has not approved any VERS in 2023-24.
Additional requirement as per FReM
£0.00 exit costs were paid in 2023-24, relating to 2022-23 (the year of departure).

Senedd Cymru / Welsh Parliamentary Accountability and Audit Report 2022/23

Regularity of Expenditure
Regularity of Expenditure Regularity is the requirement for all items of expenditure and receipts to be dealt with in accordance with the legislation authorising them, any applicable delegated authority and the rules of Government Accounting.

Aneurin Bevan University Health Board ensures that the funding provided by Welsh Ministers has been expended for the purposes intended by Welsh Ministers and that the resources authorised by Welsh Ministers to be used have been used for the purposes for which the use was authorised.

The Health Board's Chief Executive is the Accountable Officer and ensures that the financial statements are prepared in accordance with legislative requirements and the Treasury's Financial Reporting Manual. In preparing the financial statements, the Chief Executive is required to:

- observe the accounts directions issued by Welsh Ministers, including the relevant accounting and disclosure requirements and apply appropriate accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards have been followed and disclosed and explain any material departures from them; and
- prepare them on a going concern basis on the presumption that the services of the Health Board will continue in operation.

Fees and charges
Where the Health Board undertakes activities that are not funded directly by the Welsh Government the Health Board receives income to cover its costs which will offset expenditure reported under programme areas. Miscellaneous Income can be seen in Note 4 (page XX) of the Annual Accounts 2023/24. When charging for this activity the Health Board has complied with the cost allocation and charging requirements set out in HM Treasury guidance.

The Health Board incurred costs amounting to £0.455m in 2023/24 for the provision of the statutory audit by the Wales Audit Office.

Managing public money
This is the required Statement for Public Sector Information Holders as referenced in the Directors' Report. In line with other Welsh NHS bodies, the Health Board has adopted standing financial instructions which enforce the principles outlined in HM Treasury guidance 'Managing Public Money' which sets out the main principles for dealing with resources in

the UK public sector. As a result, the Health Board should have complied with the cost allocation and charging requirements of this guidance. The Health Board has not been made aware of any instances where this has not been done.

Remote Contingent Liabilities
This disclosure was introduced for the first time in 2015-16. It shows those contingent liabilities that are deemed to be extremely remote and have not been previously disclosed within the normal contingent liability note within the accounts.

The remote contingent liabilities cost consists of 3 medical negligence cases and 1 GP Indemnity case in 2023-24 (11 medical negligence cases in 2022-23). Should these cases progress the majority of the costs incurred, in excess of £25k per case attributable to the Health Board, will be recovered from the Welsh Risk Pool.

Nicola Prygodzicz
Chief Executive **Date: XX July 2024**

THE CERTIFICATE AND INDEPENDENT AUDITOR'S REPORT OF THE AUDITOR GENERAL FOR WALES TO THE SENEDD

REPORT OF THE AUDITOR GENERAL TO THE SENEDD

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	21 May 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Draft Accounts 2023-24
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Rob Holcombe, Director of Finance, Procurement and Value Based Health Care
SWYDDOG ADRODD: **REPORTING OFFICER:**	Mark Ross, Assistant Finance Director

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report gives an overview of the accounts for the full year to 31 March 2024 for Aneurin Bevan University Health Board. The accounts are prepared under International Financial Reporting Standards (IFRS).

The report supports the detailed accounts, which are attached and describes the reasons for key movements in the figures between 2022/23 and 2023/24.

The accounts are draft at this stage and subject to audit.

The Audit, Risk & Assurance Committee is asked to note this report.

Cefndir / Background

The production of annual accounts is a statutory requirement for the Health Board. Timescales for production are set by Welsh Government (WG). The draft accounts were submitted on time to WG on 3rd May. The final audited and signed accounts are to be submitted by 18th July.



The Audit, Risk & Assurance Committee have received updates on the planning process for producing this year's accounts. The accounts were delivered in line with the plan and the external audit is now well underway.

Asesiad / Assessment

Financial Performance and Financial Results

The Health Board has two statutory financial duties:

- To breakeven over a rolling three-year period.
- To submit an Integrated Medium-Term Plan (IMTP) to secure compliance with breakeven over three years.

Under the rolling 3-year duty, introduced with the NHS (Wales) Act 2014, the first assessment of the first statutory financial duty took place at the end of 2016/17 when it was achieved. The Health Board has **not** met its financial duty to breakeven against its Revenue Resource Limit over 3 years 2021-22 to 2023-24, which is set out in table 1 below.

In relation to the second duty, the LHB was unable to submit a balanced Integrated Medium-Term Plan for the period 2023-2026 in accordance with NHS Wales Planning Framework. The Health Board submitted an Annual Plan for 2023-24 with a 3-year intent to get back to a sustainable, breakeven position in the 3-year period.

In September 2023, the HB was escalated to enhanced monitoring for finance and planning.

In January 2024, the HB was escalated from enhanced monitoring to targeted intervention/level 4 for finance, strategy and planning.

The note in the accounts shows that **this duty was not achieved**. (*Note 2.3.)*

Revenue Resource Performance (*Note 2.1 Page 28*)

The Health Board did not meet its Revenue Resource Limit for the year and delivered an overspend of £49,754K. Against the breakeven duty over a rolling three-year period, the Annual Accounts 2022/23 report an overspend of £36,842k as shown in the table below:

3-year revenue breakeven duty	2021/22 £000	2022/23 £000	2023/24 £000	Total £000
Underspend/(overspend) against allocation	249	(36,842)	(49,754)	(86,347)

Capital Resource Performance (*Note 2.2 Page 28)*

In addition to a revenue resource limit the Health Board has a capital resource limit (CRL) that sets the target for capital expenditure. The target of £56,742m was met

in 2023/24 with a small underspend of £41k. The target is measured over a 3-year period as shown in the table below:

3-year capital breakeven duty	2021/22 £000	2022/23 £000	2023/24 £000	Total £000
Underspend against allocation	50	43	41	134

Public Sector Payment Policy *(Note 2.4 Page 29)*

This is another target for the Health Board which relates to the payment of 95% of its trade creditors within 30 days and which is routinely reported to the Audit, Risk & Assurance Committee. The target was achieved with full year figure of 97.4%.

Cash Balance *(Statement of Cash Flows – Page 7)*

WG sets a notional target for Health Boards to have end of period cash balances not exceeding £6m. The actual cash balance was £4.145m and therefore within the target.

Commentary Supporting Significant Movements to Previous Year's Accounts

This year has continued to be a year of challenges across the NHS and our wider communities and there are a number of significant items which reflect this and impact on the accounts and on the reported overspend of £49.8m which are listed below and reflected in the narrative that follows.

This section provides explanations to support significant movements in figures compared to the previous year.

Expenditure on Primary Healthcare Services (Note 3.1, *Page 30)*

Overall expenditure on Primary Healthcare services has increased by £18m. The main variance relates to

GMS £6.5m - The increase is due to an increase in the Global spend sum of £6.826m with a slight reduction in spend of £0.372m in relation to other areas within GMS.

Prescribed drugs £7.6m - Cost Changes Made up of:

- £2.505m in-year NCSO Concessions increased costs.
- £1.774m in-year Non-Cat M Drug tariff increases including Full Year Effect of 2022/23 changes
- £1.364m item growth (180K @£7.58 each)
- £0.942m in year Cat M drug tariff increases
- £2.7m continued increase in Diabetes drugs/Freestyle Libre
- £0.713m Other
- -£2.382m reduction in Apixaban LOE which is an Anti-Coagulant drug – Loss of Exclusivity, where a cheaper version was produced.



Expenditure on Healthcare from other providers (Note 3.2, Page 30

Overall, expenditure on healthcare from other providers has increased by £34m from 2022/2. This is mainly due to the following:

- £10m - an increase in goods and services received from WHSSC/EASC
- £13m increase in CHC spend.
- £1.6m increase in FNC spend
- £3.7M increase in private providers
- £10M increase in goods and services from other NHS HBs and Trusts
- -£6m reduction in Local Authority (LA) spend

The main reasons for the increase in spend are detailed below.

WHSSC/EASC - £10m

The increase in WHSSC/EASC spend reflects the Commissioning Plans for both organisations agreed by Chiefs Executives. Notable increases in expenditure include £2m of inflationary funding (1.5%), £4.5m of pay award costs (Welsh Government funded), £8m of Vertex Costs (Cystic Fibrosis drug funded by Welsh Government) offset by a £1.5m underspend against the WHSSC Commissioning Plan as a result of slippage on developments and in year provider performance.

CHC - £13m

Complex Care £1.8m - Inflationary uplifts of approx. 8.7% offset in part by a reduction in activity, with average placement numbers moving from 607 in 22/23 to 554 in 23/24.

Mental Health and Learning Disabilities **-** £9m. There has been an increase in spend due to the following:

- Fee uplifts were awarded to providers at a rate of 10.1% in 23/24, resulting in an increase in costs of £4.4m.
- In 22/23, historic accruals of £3m were released after review which reduced the costs non-recurrently in that year.
- In 23/24 we had an individual patient in a very high-cost package for 8 months, costing £84,000 a month (£600k).
- In addition, there is a cost of the full year effect of the 22/23 net growth impacting on 23/24.

Children - £2m**.** Increased spend is due to the following**:**

- The HB incurred a high value/complex package of care for a resident which is currently in dispute. Costs paid in 2023/24 equated to £0.231m with a further £1.538m accrued at year-end.
- Slight increase during the year in children being approved for CHC funding, however, the nature and complexities have increased which has therefore increased the cost of the packages.



FNC - £1.6m

FNC has seen a growth in activity from 22/23 levels, with average placement numbers moving from 889 in 22/23 to 1,033 in 23/24. The rate also increased per placement by 6.7%, from £193.88 to £206.95 per week.

Private Providers - £3.7m

Private providers spend increased by £3.7M from 2022/23 to 2023/24 due to the following:

- £3.1m spend through the integrated care fund
- £0.5m on External commissioning in relation to Ophthalmology
- £0.9m spend on Cardiology Echo Insourcing
- £-0.8m reduction in spend re outsourcing with St Josephs Hospital

Integrated Care Fund (ICF) - £3.1m

There was an increase in the ICF spend in 2023/24 as a result of ICF Programme Managed Schemes that were delivered and paid for in 2023/24 which involved the following schemes.

- Bridgeview
- Childrens Residential Home - complex needs - Greenhill Bungalow
- LAC Step Down (1)
- LAC Step Down (2)
- Transitional Accommodation
- Winston Osbourne House
- Re-Programme Management of unused ICF Capital Funds

Welsh Health Boards – goods and services received - £5.7m

An increase from 2022/23 of £5.7m due to the following

- £4.1m increase in LTA Cost and Volume contract
- £2.0m increase re Minor Eye – Out of Area Treatments
- £1.1m reduction in Other Secondary Care Payments
- £0.5m increase in other areas of spend

Welsh NHS Trusts – good and services received - £4m.

An increase from 2022/23 of £4.0m mainly to Velindre NHS Trust due to the following

- £3.2m increase in the LTA Cost and Volume Contract
- £0.7m SLA Courier Services – Shared Services

Local Authorities – a reduction in spend of £6.2m due to the following:

Blaenau Gwent CBC – a reduction of £0.9m due to a reduction in spend in the following areas.



- Winter Funds - £0.1m
- Minor Capital spend - £0.1m
- ICF Capital – 0.5m – Augusta House – No allocation in 2023/24
- Other £0.2m

Monmouthshire CBC – a reduction in spend of £3.6m due to the following:

- Capital ICF - £3.2M – grant funding for ICF Programme Managed Scheme – Crick Road allocation paid in 2023/24 – no further allocation paid out in 2023/24.
- Other - £0.4m

Newport CBC – a reduction in spend of £1.9m due to the following.

- Winter Funds - £0.11m
- ICF Capital - £0.62m reduction in allocation in 2023/24
- Gwent Test, Trace and Protect - £0.81m
- Support for unpaid carers - £0.28m
- Other - £0.08m

Expenditure on Hospital and Community Health Services (Note 3.3, Page 31)

Staff Costs (Page 30 – Note 3.1 and Page 31 – Note 3.3)

The most significant movements relate to the decrease in staff numbers in relation to agency staff.

The following Table shows an analysis of underlying staff costs for the year followed by some key points:

Staff Costs	2023/24 £M	2022/23 £M	Movement £M		Movement 2022/23 £M
Directors Costs	2	2	(0)		0
Staff Costs Note 3.1 & 3.3	810	749	60		38
Single Lead Employer	32	30	2		14
Total Pay as per Note 9.1	844	782	63		53
Reasons for Increase					
Agency Costs			(19)		4
Increase in Permanent			16		1
Increase in SLE staff			2		14
Pay Award costs as per modelling			56		44
Employers Contribution to Pension Scheme - 6.3% increase			4		2
Impact of Strike Action			2		0
COVID Annual Leave accrual			(0)		(16)
Overtime - service related pressures			0		1
Other			2		4
Adjusted for Comparison			63		53



In 2019/20 there was an increase in the Employers pension contribution from 14.38% to 20.68%. The Health Board continued to pay the 14.38% with Welsh Government paying the additional sum on behalf of the Health Board of 6.3%. This arrangement continued in 2023/24. To ensure that this cost was reflected in the Health Boards accounts a notional adjustment was actioned in month twelve to account for this with funding allocated. The value of the 6.3% pension increases in 2023/24 was £32.065m (2022/23 - £28.427m). The other side of this transaction is shown in note 28 under other cash flow adjustments.

Average staff number of employees grew by 83. The increase in staff numbers of 83 from 2022/23 is made up of 437 permanent staff, a reduction of 16 staff on inward secondment, a reduction of 343 staff relating to agency, 11 relating to Single Lead employer and a reduction of 6 staff relating to Retinue *(Note 9.2 Page 35). The table below provides further analysis of the increase by staff group.*

Average Number of Employees	2023-24	2022-23	Variance
Administrative, clerical and board memgers	2,761	2,727	34
Medical & Dental	1,338	1,260	78
Nursing, midwifery registered	4,012	3,990	22
Professional, Scientific, and technical staff	452	462	(10)
Additional Clinical Services	2,841	2,877	(36)
Allied Health Professions	876	829	47
Healthcare Scientists	247	245	2
Estates and Ancilliary	1,093	1,146	(53)
Students	9	10	(1)
Total	13,629	13,546	83

The table below shows how agency costs and WTEs have decreased in 2023/24 compared to 2022/23.

Staffing Group	**2023-24 Expenditure £000**	**2022-23 Expenditure £000**		**2023-24 Average WTE**	**2022-23 Average WTE**
Administrative, Clerical and board members	705	1,536		6	30
Medical and dental	14,664	15,929		73	102
Nursing, midwifery registered	17,704	22,000		196	248
Professional, Scientific, and technical staff	317	160		3	2
Addittional Clinical Services	1,891	10,601		37	209
Allied Health Professions	1,831	2,142		19	27
Healthcare Scientists	402	795		5	11
Estates and Ancilliary	4,814	7,722		98	171
Total	**42,328**	**60,886**		**437**	**800**



Agency costs in the tables above are included in notes 3.1 page 30 and 3.3 page 31.

The table below shows the breakdown of the decrease in agency costs by staffing group.

Staffing Group	2023-24 Expenditure £m	2022-23 Expenditure £m	Movement £m
Administrative, Clerical and board members	0.7	1.5	-0.8
Medical and dental	14.7	15.9	-1.3
Nursing, midwifery registered	17.7	22.0	-4.3
Professional, Scientific, and technical staff	0.3	0.2	0.2
Addittional Clinical Services	1.9	10.6	-8.7
Allied Health Professions	1.8	2.1	-0.3
Healthcare Scientists	0.4	0.8	-0.4
Estates and Ancilliary	4.8	7.7	-2.9
Total	**42.3**	**60.9**	-18.6

The key drivers to the decrease in agency expenditure are: -

- Reduction in HCSW agency as part of the variable pay reduction plans.
- Patient safety reviews reducing the level of enhanced care requirement resulting in reduced agency spend.
- Reduced nursing agency by improved recruitment and increased substantive costs.
- Some reduction in agency expenditure linked to Covid-19 health protection/vaccination reduced agency plans.
- Enhanced Cleaning and other facilities agency expenditure decreases partly linked to substantive appointments but also due to specific savings opportunities.
- Medical agency decreases linked to savings and efficiency plans.
- Capacity movements/reductions in quarter 4 have also reduced the agency requirement across the organisation.

Non-Pay Costs (Note 3.3, Page 31)

Non pay costs within the accounts are part of note 3.3 and are summarised as follows:

Non Pay Analysis	2023/24 £M	2022/23 £M	Movement £M
Expenditure on Hospital & Community Services	1,105	1,004	
Less Director & Staff Costs	821	762	
	284	242	
Exclude Non-Cash Items			
Depreciation	-47	-47	
Amortisation	-2	-3	
Impairments	-10	19	
Losses	-3	-2	
	221	210	11
Add Inflation per RPI - Average 12 mths	-11	0	-11
Adjusted Comparators	209	210	-0

The above reflects the underlying inflation which last year was an average of 5.38% increase.

Specific movements in Note 3.3 are in relation to supplies and services – clinical of £10.0m and premises of £4.4m and other £5m which are discussed in more detail below.

Supplies & Services – Clinical

Increase from £120.7m in 2022/23 to £130.7m in 2023/24. This is an increase in year of £10m which is mainly due to:

Increase in spend

- £2.5m in drugs costs
- £1.2m in Laboratory Reagents
- £1.0m in FP10s
- £1.0m in Medical & Surgical Equipment (M&SE) Disposable
- £1.0m in Hire of M&SE Equipment
- £0.82m in Laboratory Test Kits
- £0.75m in purchase of patients appliances
- £0.36m in pacemakers
- £1.37m Other increases and decreases in spend

Premises

Decreased from £48.3m in 2022/23 to £43.9m in 2023/24. This is a decrease in year of £4.4m.

The premises category includes expenditure on areas such as Utilities and Business Rates and also the Rent charges for the Health Board's various sites.

There was a significant decrease in utility costs in relation to Gas - £5m reduction in year, offset by £2.3m increase in Computer Software/License Fees and a decrease in spend due to premises lease rental of £2.8m.



Other

Other expenditure increased by £5m from 2022/23 to 2023/24 due to the following.

- £1.4m Salary Sacrifice Lease Cars
- £1.5m Recruitment Agency Introduction fees
- £1.1m Tec Cymru
- £0.2m Legal Fees
- £0.8m other increases and decreases in spend

Depreciation

Depreciation has increased overall by £0.065m compared to 2022/23. This is the net result of a combination of factors, including an increase of £0.461m arising against buildings due to indexation uplifts applied as at 1st April 2022, and a decrease of £0.396m against non-property assets.

Fixed Asset Impairments

A detailed analysis of impairment charges is shown in the table below.

Fixed Asset Impairments and Reversals	**£m**	**Reason for impairment**
Indexation - Land	397	Downward revaluation of land following the indexation decrease applied at 1st April 2023.
Bevan Health and well-being Centre	13,403	Assets Under Construction valued on coming into use
Endoscopy Unit, Royal Gwent Hospital	5,978	Assets Under Construction valued on coming into use
Ysbyty Ystrad Fawr Unified Breast Unit	5,796	Assets Under Construction valued on coming into use
Works to Nevill Hall Hospital in relation to the discovery of Reinforced Autoclaved	3,199	Economic Loss / Assets Under Construction valued on coming into use
Grange House Wellbeing Centre, Llanfrechfa	511	Assets Valued on Coming Into Use
Welsh Community Care Iinformation System Phase 2	438	Abandoned development - Asset Under Construction written off
Reversals of Impairment	-19,552	Indexation Gains - reversal of impairment in previous years
Total Impairment	**10,170**	

Losses, special payments, and irrecoverable debts: charges to operating expenses (Note 3.4, *Page 31*)

Clinical Negligence has increased from £-3.01m in 2022/23 to £73.3m in 2023/24. During 2023-24 there was a large increase in Clinical Negligence provisions based on the quantum reports provided at the end of March 2024. This is largely offset by movement in income received/receivable from WRP.

Personal injury has also increased from £0.2m in 2022/23 to £0.7m in 2023/24 based on the quantum reports provided at the end of March 2024. Again, this is largely offset by movement in income received/receivable from WRP.

All other losses and special payments increased in year by £0.79m mainly due to the loss incurred due to the flood damage at the Royal Gwent Hospital - £0.75m.



Miscellaneous Income (Note 4, Page 32)

Welsh Government Income

The accounts show an increase in the income received from Welsh Government of £2.2m. This increase is as a result of a presentational change from 2022/23 to 2023/24 where the SIFT income was previously shown against Education, Training and Research but has now been shown under Welsh Government. In accordance with the Manual for Accounts the SIFT income from WG in 2023/24 will be moved to the Education, Training and Research line within the final audited accounts.

Welsh Health Specialised Services Committee (WHSSC)/Emergency Ambulance Services Committee (EASC)

An increase if £2.4m due to an increase in the LTA income

Welsh Special Health Authorities Income

An increase of £2m in 2023/24 due to

- £1.8m increase = HEIW
- £0.7m increase Junior Doctors income,
- £0.3m increase EPU/PME income,
- £1.1m increase Education & Training income
- £0.3m decrease re other income (mainly due to healthcare support funding received in 22/23)

Local Authorities

An increase of £1.2m mainly due to Caerphilly County Council £1.3m of which £0.9m relates to frailty.

Education, Training and Research

A reduction of £2m due to a change in the classification of SIFT income from Welsh Government which for 2023/24 has been shown under Welsh Government within note 4. This will be corrected for the final audited accounts.

Other income

Increase from £13.8m in 2022/23 to £15.5m in 2023/24. This is an increase in year of £1.7m due to the following:

- £1.7m increase in relation to salary sacrifice scheme and fleet vehicles income
- £0.7m increase in VAT recovered mainly as a result of the recovery of VAT on Home Oxygen supplies
- £1.2m reduction in Integrated Care Fund income - which is programme managed with Housing Associations partners.
- £0.5m other

Fair Pay disclosure Remuneration Relationship (Note 9.6.1, page 37)

The Health Board introduced apprenticeships in 2022/23 for the first time which resulted in the lowest level of remuneration reducing from £19K in 2021/22 which was the bottom of the A4C pay scales to £14K on 2022/23. In 2023/24 this has increased to £15K which relates to the apprentice rate.

The highest paid director was the Chief Executive Officer, the highest paid Health Board employee was a consultant earning £383K in 2023/24.

Percentage Changes (Note 9.6.2, page 37)

The 5% increase related to the increase of the median point of the chief executive pay from £217,500 to £227,500. The 7% increase related to the average salary increasing from £40,098 in 2022-23 to £42,960 in 2023-24 mainly due to pay award during the year.

Prompt payment policy – measure of compliance (Note 10.1, *Page 40*)

The number of Non-NHS invoices processed has decreased by 44,062 from 2022/23 to 2023/24. This is mainly due to a decrease in agency spend of £18m.

Property, Plant and Equipment (Page 4 and Note 11.1, Page 41)

The main changes in the year can be summarised as follows:

Property, Plant & Equipment	**£m**
Balance as at 1 April 2023	**869.6**
Indexation	18.8
Additions	57.7
Reclassification	-0.5
Revaluations	0.6
Impairments	-29.3
Reversals of Impairments	19.5
Depreciation	-43.0
Disposals	-0.6
Balance at 31 March 2024	**892.8**

The key movements in the year relate to:

- the additions of £57.7m relating to the Capital Programme investments including expenditure on Tredegar Health and Well-being centre (£3.475m), Endoscopy Services redevelopment at RGH (£4.910m), Newport East Health & Well-being Centre (£10.046m), YYF Unified Breast Unit (£8.371m), NHH Satellite Radiotherapy Unit and Enabling Works (£14.987m), Grange Emergency Department extension (£2.827m) and Neville Hall RAAC works (£0.770m).



- an increase of £38.3m to land and buildings values from the application of indexation based on indices received from the VOA, applied at 1st April 2023. The increase is shown either against indexation or, for those assets that have been impaired previously, reversals of impairment.

- the impairment of £29.3m mainly relating to buildings at five sites including Tredegar Health and Well-being Centre, Royal Gwent Hospital, Ysbyty Ystrad Fawr, Nevill Hall Hospital and Grange House Llanfrechfa Nevill Hall Hospital following the revaluation of the buildings required when bringing each asset under construction into use.

- Depreciation charges of £43m.

There were no assets held for sale as at 31st March 2024.

Asset lives are applied in line with the policy in the accounts and are reviewed annually. Where there is evidence that standard lives have changed (e.g., due to legislation), the lives are adjusted. Fully depreciated assets are carried at nil net book value.

Right of Use Assets (Note 11.3, Page 45)

Right of Use assets are leases / contracts that convey the right to use an asset for a period of time in exchange for consideration. The Health Board applies an exemption, and therefore does not capitalise, leases that are less than 12 months in duration or where the underlying asset is of a value less than £5,000. Leases that are not excluded by the exemption rules are recorded in the balance sheet as a "Right of Use" asset with a corresponding liability for outstanding payments. The assets are depreciated over the term of the lease.

The main changes in the year can be summarised as follows:

ROU Assets	**£m**
Balance as at 1 April 2023	**23.867**
Additions	3.271
Disposals other than by sale	-5.294
Depreciation as at 31 March 2023	-4.474
Net Book Value at 31 March 2024	**17.370**

The key movements in year relate to:

- New leases were approved in year totalling £3.271m including Ty Gwent (£1.222m), Ty Clarence (£0.143m), other existing property lease extensions and rent increases (£0.402m), extension of the IT PACS managed service contract (£0.385m), Vehicle leases (£0.534m) and various equipment leases (£0.585m).

- Disposals in year of £4.294m, the majority of which relates to the early termination of five managed practice leases (Aberbeeg Medical Centre, Brynmawr Medical Centre, Markham Medical Centre, Blaenavon Primary



Care Resource Centre, and Bryntirion Surgery) which are being taken over by independent contractors.

- Depreciation charges in year of £4.474m.

The Right of Use Liabilities as at 31st March 2024 are detailed below:

Lease Liabilities (net of Irrecoverable VAT)	£m
Current	3.445
Non-Current	12.892
Total	16.337

Note – the asset and liability will not match exactly due to the differences in lease and asset accounting, largely related to the application of interest on the liability.

Trade and Other Receivables (Note 15, *Page 4 and 53*)

Trade and Other Receivables have increased from £229.6m in 2022/23 to £280.6 in 2023-24– a increase of £51mm. This is due to the following:

- Welsh Risk Pool (WRP)income increased by £50.2m

The decrease in the WRP debtor is largely attributable to the increase in the Clinical Negligence and Personal Injury provision required based on the latest legal assessment.

There is £15.6m decrease in the current debtor with an increase of £65.8m in the non-current debtor which reflects the expectation of claims being settled within the coming year and future years.

Other reductions in Trade and Other Receivables related to

- Local Authority Income – reduced by £4m due to the Q2&Q3 Frailty invoices that were outstanding at the end of 2023/24 with payment received in 2023/24.
- Other receivables – reduction of £4m relating to 2 invoices re Melin Homes £2m and Pobl Group £2.8m outstanding at the end of March 2023. Similar invoices were not raised in 2023/24.

Trade and Other Payables (Note 18, *Page 4 and Page 56*)

Trade and other payables have decreased from £242.8m in 2022/23 to £218.0m in 2023-24, a decrease of £24.8m. This is mainly due to the following:

- Welsh Health Boards increase of £2.5m due to:
  C&V increase of £1.1m due to LTA settlement
  Cwm Taf increase of £1.0m due to LTA settlement.
  111 project risk share increase of £0.3m

- Other NHS increase of £3m due to increase in LTAs with North Bristol, Gloucestershire & Wye Valley along with an increase of £0.750m for Gloucestershire Health and Social Care NHS Trust Mental Health SLA.

- Local Authorities decreased by £7.6m due to:
  Caerphilly CBC frailty quarters 2&3 invoices were outstanding at the end of 2022/23 totalling £5m, subsequently paid in 2023/24.
  Monmouthshire CC Regional Partnership Board – Crick Road £2m accrued in 2022/23not required in 2023/24.

- Non-NHS Accruals decreased by £14m due to
  Pay award of £9.5m accrued in 2022/23, paid in 2023/24.
  CHC Community – decrease in accruals of £1.8M
  CHC Mental Health – Decrease in accruals of £1.1m
  Rates Utility accruals decreased by £1m.

- ROU lease liability reduced by £6.1m. See table under the ROU section above.

Provisions (Note 20, *Page 58*)

Provisions for clinical negligence and personal injury have increased £51.2m from £162.1m in 2022/23 to £213.3m in 2023/24 reflecting up to date legal assessment of pending litigation claims against the Health Board. Most of this increase is offset by an equal level of increased assumed income from the Welsh Risk Pool.

Current Provisions – decrease of £17m.

During 2023/24 we had £11m which was transferred to WRP as structured settlements were agreed along with £28m utilised, there was also £-4m transferred to creditors for settlements agreed but not yet paid, these together have led to a £34m reduction in provision which has been offset by net arisings of £17m.

Non-Current provisions – increase of £68m.

The increase in Non-Current Provision relates in the main to an increase in Clinical Negligence cases which have been assessed and a provision provided based on the latest information as at 31.03.2024.

From 2022/23 to 2023/24 the number of clinical negligence cases increased from 230 to 285, with personal injury cases increasing from 78 to 122 and redress cases increasing from 26 to 58. The increase in cases is driving the increase in the provision required for 2023/24.

Other provisions have increased from £6.3m in 2022/23 to £8.2m in 2023/24 mainly relating to increased Capital provisions and GP/Dental Annual leave provision.

Pensions tax annual allowance – Scheme Pays arrangements 2023/24 (Page 60)



WG confirmed that the costs associated with Scheme pays were to be included in the Health Boards accounts from 2021/22. In 2022/23 the amount included within provisions was £141K which was included in Note 20 Provisions with the funding from WG reflected in Note 15 – Trade and Other receivables. In 2023/24 revised discounted figures have been provided by Welsh Government via GAD which has increased the Health Board required provision to £604K which as per last year has been reflected in note 20 and the associated income reflected in note 15.

Welsh Government also made £2K of payments during the year in relation to scheme pays which has been included in the Health Board accounts with the notional funding received from WG to offset this which is included within the 'other' amount in note 28.

In 2022-23, Audit Wales confirmed in the draft audit plan that whilst any transactions included in the Health Board's financial statements strictly remain irregular, they did not classify them as material by their nature. They have also confirmed that a further qualification of regularity opinion would have a diminishing value, particularly against the backdrop of the Chancellor of the Exchequer abolishing the Lifetime Allowance in his March 2023 budget statement.

The above still applies for 2023/24 and as such no regularity opinion will be placed on this years accounts in line with last year.

Remote Contingent Liabilities (Note 21.2, *Page 62*)

Remote Contingent Liabilities have decreased £33.8m in 2022/23 to £24.1m in 2023/24. These are 3 Medical Negligence cases and 1 GP Indemnity case in 2023/24 which have been assessed as having less than a 5% probability of being settled. The liability is based on what legal services assess the costs/settlements would be if these cases progress to settlement. The Medical Negligence case values for 2023/24 were £15.4m, £8.6m and £0.064m with the GP Indemnity case value of £0.025m. There were 11 Medical Negligence cases in 2022-23 ranging in value from £0.045m to £15.5m.

Other Information

Annual Leave Accrual

The remaining balance which related to junior doctors' study leave has been reviewed and based on the revised information received re outstanding days payrates was reduced from £3.4m to £3.2m. This study leave accrual has not been released because Health Education and Improvement Wales, who determine the arrangements for junior doctors' study leave, have chosen to retain the pre-Covid arrangements for at least another year.

Action from the Audit, Risk and Assurance Committee relating to losses as follows:



November 2023	ARAC 2811/3.1 Losses and Payments Report	Circulate a briefing note to Committee Members detailing the Losses and Special Payments made by the Health Board.	Director of Finance and Procurement	21 May 2024	In Progress

Appendix 1 shows trend analysis for the past 5 years from 2019-20 to 2023-24 for all losses cases and the amount paid out in total split between the HB element and the Welsh Risk pool element including the number of claims in each category. This demonstrates that there has been a significant rise on the number of claims in 2022/23 compared to previous years.

Argymhelliad / Recommendation

The Audit, Risk & Assurance Committee is asked to note this report

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 3.5 Record Keeping Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	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. Improve the wellbeing and engagement of our staff

Gwybodaeth Ychwanegol: Further Information:

Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	IFRS – International Financial Reporting Standards NCSO – No Cheaper Stock Obtainable LOE – Loss of Exclusivity CHC – Continuing Health Care FNC – Funded Nursing Care LAC – Looked After Children LTA – Long Term Agreement SLA – Service Level Agreement WTE – Whole Time Equivalent EPU – Education Purchasing Unit PME – FP10 – Drugs prescribed in our hospitals, but prescription is dispensed in community pharmacies. SIFT – Service Increment for Teaching IMTP – Integrated Medium-Term Plan CRL – Capital Resource Limit ROU – Right of Use ICF – Intermediate Care Fund GAD – Government Actuary's Department
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment: • **Workforce** • **Service Activity & Performance** • **Financial**	**Is EIA Required and included with this paper?** A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following: Yes, outlined within the paper Yes, outlined within the paper Yes, outlined within the paper
Asesiad Effaith Cydraddoldeb	**No does not meet requirements**



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

Payments

	2019-20				2020-21				2021-22				2022-23				2023-24			
	No. of Cases	Amount of Loss or Payment			No. of Cases	Amount of Loss or Payment			No. of Cases	Amount of Loss or Payment			No. of Cases	Amount of Loss or Payment			No. of Cases	Amount of Loss or Payment		
		ABUHB £'000	Welsh Risk Pool £'000	TOTAL £'000		ABUHB £'000	Welsh Risk Pool £'000	TOTAL £'000		ABUHB £'000	Welsh Risk Pool £'000	TOTAL £'000		ABUHB £'000	Welsh Risk Pool £'000	TOTAL £'000		ABUHB £'000	Welsh Risk Pool £'000	TOTAL £'000
LOSSES:																				
Bad Debts	169	69	0	69	97	24	0	24	59	17	0	17	16	3	0	3	92	20	0	20
Damage to buildings, property etc	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	751	0	751
SPECIAL PAYMENTS:																				
Loss of personal effects	40	14	0	14	40	18	0	18	54	33	0	33	30	13	0	13	12	8	0	8
Clinical negligence with advice	224	1,503	8,429	9,932	234	1,557	9,289	10,847	243	1,651	11,285	12,936	258	1,433	21,601	23,034	285	1,846	25,561	27,277
Personal injury with advice (includes Permanent Injury Benefit)	79	547	35	583	76	552	104	656	113	622	403	1,025	119	740	557	1,298	122	676	551	1,227
Other clinical negligence and personal injury	55	49	363	413	46	31	205	237	48	51	333	384	26	22	136	158	52	29	265	293
Other	23	186	0	186	13	122	0	122	24	29	0	29	16	624	0	624	58	56	0	56
TOTAL LOSSES AND SPECIAL PAYMENTS	**590**	**2,369**	**8,828**	**11,196**	**506**	**2,305**	**9,599**	**11,904**	**541**	**2,402**	**12,021**	**14,423**	**465**	**2,835**	**22,295**	**25,130**	**622**	**3,386**	**26,376**	**29,634**
Of which, cases of £300,000 or more:																				
Damage to buildings, property etc	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	751	0	751
Clinical negligence with advice	5	43	4,719	4,762	8	21	5,830	5,851	6	11	8,084	8,094	12	34	17,650	17,684	11	30	19,483	19,513
Personal Injury with advice	0	0	0	0	0	0	0	0	0	0	0	0	1	3	459	603	1	21	350	371
Other	0	0	0	0	0	0	0	0	0	0	0	0	1	603	0	603	0	0	0	0

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

FOREWORD

These accounts have been prepared by the Local Health Board under schedule 9 section 178 Para 3(1) of the National Health Service (Wales) Act 2006 (c.42) in the form in which the Welsh Ministers have, with the approval of the Treasury, directed.

Statutory background

The Local Health Board was established on 1st October 2009 following the merger of Gwent Healthcare NHS Trust and the following Local Health Boards.
Blaenau Gwent Local Health Board
Caerphilly Local Health Board
Monmouthshire Local Health Board
Newport Local Health Board
Torfaen Local Health Board

The Health Board covers the areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen with a population of approximately 600,000 people. The Health Board has an annual budget from the Welsh Government of just over £1.6 billion per year from which we plan and deliver services for the population of the Health Board area. The Health Board, as well as providing services locally, works in partnership to seek to improve health and well-being in the area, particularly through our partnership arrangements to respond to the Social Services and Well-Being Act and the Well Being of Future Generations Act.

Performance Management and Financial Results

Welsh Health Circular WHC/2016/054 replaces WHC/2015/014 'Statutory and Administrative Financial Duties of NHS Trusts and Local Health Boards' and further clarifies the statutory financial duties of NHS Wales bodies and is effective for 2021-22. The annual financial duty has been revoked and the statutory breakeven duty has reverted to a three year duty, with the first assessment of this duty in 2016-17.

Local Health Boards in Wales must comply fully with the Treasury's Financial Reporting Manual to the extent that it is applicable to them. As a result, the Primary Statement of in-year income and expenditure is the Statement of Comprehensive Net Expenditure, which shows the net operating cost incurred by the LHB which is funded by the Welsh Government. This funding is allocated on receipt directly to the General Fund in the Statement of Financial Position.

Under the National Health Services Finance (Wales) Act 2014, the annual requirement to achieve balance against Resource Limits has been replaced with a duty to ensure, in a rolling 3 year period, that its aggregate expenditure does not exceed its aggregate approved limits.

The Act came into effect from 1 April 2014 and under the Act the first assessment of the 3 year rolling financial duty took place at the end of 2016-17.

Statement of Comprehensive Net Expenditure for the year ended 31 March 2024

	Note	2023-24 £000	2022-23 £000
Expenditure on Primary Healthcare Services	3.1	**325,276**	307,116
Expenditure on healthcare from other providers	3.2	**508,398**	474,153
Expenditure on Hospital and Community Health Services	3.3	**1,105,256**	1,004,067
		1,938,930	1,785,336
Less: Miscellaneous Income	4	**(121,956)**	(109,566)
LHB net operating costs before interest and other gains and losses		**1,816,974**	1,675,770
Investment Revenue	5	**(17)**	(18)
Other (Gains) / Losses	6	**331**	(530)
Finance costs	7	**1,168**	1,060
Net operating costs for the financial year		**1,818,456**	**1,676,282**

See note 2 on page 28 for details of performance against Revenue and Capital allocations.

The notes on pages 8 to 75 form part of these accounts.

Other Comprehensive Net Expenditure

	2023-24 £000	2022-23 £000
Net (gain) / loss on revaluation of property, plant and equipment	**(19,417)**	(47,165)
Net (gain)/loss on revaluation of right of use assets	**0**	(17)
Net (gain) / loss on revaluation of intangibles	**(114)**	0
(Gain) / loss on other reserves	**0**	0
Net (gain)/ loss on revaluation of PPE & Intangible assets held for sale	**0**	0
Net (gain)/loss on revaluation of financial assets held for sale	**0**	0
Impairment and reversals	**0**	0
Transfers between reserves	**0**	0
Transfers to / (from) other bodies within the Resource Accounting Boundary	**0**	0
Reclassification adjustment on disposal of available for sale financial assets	**0**	0
Other comprehensive net expenditure for the year	**(19,531)**	(47,182)
Total comprehensive net expenditure for the year	**1,798,925**	1,629,100

The notes on pages 8 to 75 form part of these accounts.

Statement of Financial Position as at 31 March 2024

	Notes	31 March 2024 £000	31 March 2023 £000
Non-current assets			
Property, plant and equipment	11	**892,817**	869,541
Right of Use Assets	11.3	**17,370**	23,867
Intangible assets	12	**4,685**	5,091
Trade and other receivables	15	**144,066**	77,466
Other financial assets	16	**667**	726
Total non-current assets		**1,059,605**	976,691
Current assets			
Inventories	14	**9,844**	9,576
Trade and other receivables	15	**136,573**	152,162
Other financial assets	16	**59**	58
Cash and cash equivalents	17	**4,145**	4,704
		150,621	166,500
Non-current assets classified as "Held for Sale"	11	**0**	0
Total current assets		**150,621**	166,500
Total assets		**1,210,226**	1,143,191
Current liabilities			
Trade and other payables	18	**(202,150)**	(222,124)
Other financial liabilities	19	**0**	0
Provisions	20	**(71,827)**	(87,280)
Total current liabilities		**(273,977)**	(309,404)
Net current assets/ (liabilities)		**(123,356)**	(142,904)
Non-current liabilities			
Trade and other payables	18	**(15,888)**	(20,692)
Other financial liabilities	19	**0**	0
Provisions	20	**(149,647)**	(81,186)
Total non-current liabilities		**(165,535)**	(101,878)
Total assets employed		**770,714**	731,909
Financed by :			
Taxpayers' equity			
General Fund		**581,390**	552,847
Revaluation reserve		**189,324**	179,062
Total taxpayers' equity		**770,714**	731,909

The financial statements on pages 2 to 7 were approved by the Board on 11 July 2024 and signed on its behalf by:

Chief Executive and Accountable Officer …….. Date: 11 July 2024

The notes on pages 8 to 75 form part of these accounts.

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2024

	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Changes in taxpayers' equity for 2023-24			
Balance as at 31 March 2023	552,847	179,062	**731,909**
NHS Wales Transfer	0	0	**0**
RoU Asset Transitioning Adjustment	0	0	**0**
Impact of IFRS 16 on PPP/PFI Liability	(1,543)	0	**(1,543)**
Balance at 1 April 2023	551,304	179,062	**730,366**
Net operating cost for the year	(1,818,456)		**(1,818,456)**
Net gain/(loss) on revaluation of property, plant and equipment	0	19,417	**19,417**
Net gain/(loss) on revaluation of right of use assets	0	0	**0**
Net gain/(loss) on revaluation of intangible assets	0	114	**114**
Net gain/(loss) on revaluation of financial assets	0	0	**0**
Net gain/(loss) on revaluation of assets held for sale	0	0	**0**
Impairments and reversals	0	0	**0**
Other Reserve Movement	0	0	**0**
Transfers between reserves	9,269	(9,269)	**0**
Release of reserves to SoCNE	0	0	**0**
Transfers to/from LHBs	0	0	**0**
Total recognised income and expense for 2023-24	(1,809,187)	10,262	**(1,798,925)**
Net Welsh Government funding	1,807,206		**1,807,206**
Notional Welsh Government Funding	32,067		**32,067**
Balance at 31 March 2024	581,390	189,324	**770,714**

Notional Welsh Government funding line includes the 6.3% staff employer pension and Pensions Annual Allowance Charge Compensation Scheme (PAACCS) costs paid centrally by Welsh Government.

Notional Welsh Government funding split*;*
Notional 6.3% staff employer pension £32,065,000
Pensions Annual Allowance Charge Compensation Scheme (PAACCS) £2,000

The notes on pages 8 to 75 form part of these accounts.

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2023

	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Changes in taxpayers' equity for 2022-23			
Balance at 31 March 2022	530,429	133,026	**663,455**
NHS Wales Transfer	1,106	0	**1,106**
RoU Asset Transitioning Adjustment	820	0	**820**
Balance at 1 April 2022	532,355	133,026	**665,381**
Net operating cost for the year	(1,676,282)		**(1,676,282)**
Net gain/(loss) on revaluation of property, plant and equipment	0	47,165	**47,165**
Net gain/(loss) on revaluation of right of use assets	0	0	**0**
Net gain/(loss) on revaluation of intangible assets	0	0	**0**
Net gain/(loss) on revaluation of financial assets	0	0	**0**
Net gain/(loss) on revaluation of assets held for sale	0	0	**0**
Impairments and reversals	0	0	**0**
Other reserve movement	0	0	**0**
Transfers between reserves	1,129	(1,129)	**0**
Release of reserves to SoCNE	0	0	**0**
Transfers to/from LHBs	0	0	**0**
Total recognised income and expense for 2022-23	(1,675,153)	46,036	**(1,629,117)**
Net Welsh Government funding	1,667,210		**1,667,210**
Notional Welsh Government Funding	28,435		**28,435**
Balance at 31 March 2023	552,847	179,062	**731,909**

Notional Welsh Government funding line includes the 6.3% staff employer pension and Pensions Annual Allowance Charge Compensation Scheme (PAACCS) costs paid centrally by Welsh Government.

Notional Welsh Government funding split*;*
Notional 6.3% staff employer pension £28,427,000
Pensions Annual Allowance Charge Compensation Scheme (PAACCS) £8.270.

The notes on pages 8 to 75 form part of these accounts.

Statement of Cash Flows for year ended 31 March 2024

	Notes	2023-24 £000	2022-23 £000
Cash Flows from operating activities			
Net operating cost for the financial year		**(1,818,456)**	(1,676,282)
Movements in Working Capital	27	**(69,074)**	26,776
Other cash flow adjustments	28	**175,424**	46,683
Provisions utilised	20	**(30,160)**	(15,442)
Net cash outflow from operating activities		**(1,742,266)**	(1,618,265)
Cash Flows from investing activities			
Purchase of property, plant and equipment		**(58,252)**	(39,158)
Proceeds from disposal of property, plant and equipment		**215**	591
Purchase of intangible assets		**(1,778)**	(1,932)
Proceeds from disposal of intangible assets		**0**	0
Payment for other financial assets		**0**	0
Proceeds from disposal of other financial assets		**0**	0
Payment for other assets		**0**	0
Proceeds from disposal of other assets		**0**	0
Net cash inflow/(outflow) from investing activities		**(59,815)**	(40,499)
Net cash inflow/(outflow) before financing		**(1,802,081)**	(1,658,764)
Cash Flows from financing activities			
Welsh Government funding (including capital)		**1,807,206**	1,667,210
Capital receipts surrendered		**0**	0
Capital grants received		**0**	62
Capital element of payments in respect of finance leases and on-SoFP PFI Schemes		**0**	0
Capital element of payments in respect of on-SoFP PFI		**(1,585)**	(947)
Capital element of payments in respect of Right of Use Assets		**(4,099)**	(4,577)
Cash transferred (to)/ from other NHS bodies		**0**	0
Net financing		**1,801,522**	1,661,748
Net increase/(decrease) in cash and cash equivalents		**(559)**	2,984
Cash and cash equivalents (and bank overdrafts) at 1 April 2023		**4,704**	1,720
Cash and cash equivalents (and bank overdrafts) at 31 March 2024		**4,145**	4,704

The notes on pages 8 to 75 form part of these accounts.

Notes to the Accounts

1. Accounting policies

The Minister for Health and Social Services has directed that the financial statements of Local Health Boards (LHB) in Wales shall meet the accounting requirements of the NHS Wales Manual for Accounts. Consequently, the following financial statements have been prepared in accordance with the 2023-24 Manual for Accounts. The accounting policies contained in that manual follow the 2023-24 Financial Reporting Manual (FReM) in accordance with international accounting standards in conformity with the requirements of the Companies Act 2006, to the extent that they are meaningful and appropriate to the NHS in Wales.

Where the LHB Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the LHB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the LHB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1. Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets and inventories.

1.2. Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3. Income and funding

The main source of funding for the LHBs are allocations (Welsh Government funding) from the Welsh Government within an approved cash limit, which is credited to the General Fund of the LHB. Welsh Government funding is recognised in the financial period in which the cash is received.

Non-discretionary funding outside the Revenue Resource Limit is allocated to match actual expenditure incurred for the provision of specific pharmaceutical, or ophthalmic services identified by the Welsh Government. Non-discretionary expenditure is disclosed in the accounts and deducted from operating costs charged against the Revenue Resource Limit.

Funding for the acquisition of fixed assets received from the Welsh Government is credited to the General Fund.

Miscellaneous income is income which relates directly to the operating activities of the LHB and is not funded directly by the Welsh Government. This includes payment for services uniquely provided by the LHB for the Welsh Government such as funding provided to agencies and non-activity costs incurred by the LHB in its provider role. Income received from LHBs transacting with other LHBs is always treated as miscellaneous income.

From 2018-19, IFRS 15 Revenue from Contracts with Customers has been applied, as interpreted and adapted for the public sector, in the FREM. It replaces the previous standards IAS 11 Construction Contracts and IAS 18 Revenue and related IFRIC and SIC interpretations. The potential amendments identified as a result of the adoption of IFRS 15 are significantly below materiality levels.

Income is accounted for applying the accruals convention. Income is recognised in the period in which services are provided. Where income had been received from third parties for a specific activity to be delivered in the following financial year, that income will be deferred.

Only non-NHS income may be deferred.

1.4. Employee benefits

1.4.1. Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.4.2. Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The latest NHS Pension Scheme valuation results indicated that an increase in benefit required a 6.3% increase (14.38% to 20.68%) which was implemented from 1 April 2019.

As an organisation within the full funding scope, the joint (in NHS England and NHS Wales) transitional arrangement operated from 2019-20 where employers in the Scheme would continue to pay 14.38% employer contributions under their normal monthly payment process, in Wales the additional 6.3% being funded by Welsh Government directly to the Pension Scheme administrator, the NHS Business Services Authority (BSA the NHS Pensions Agency).

However, NHS Wales' organisations are required to account for **their staff** employer contributions of 20.68% in full and on a gross basis, in their annual accounts. Payments made on their behalf by Welsh Government are accounted for on a notional basis. For detailed information see Other Note within these accounts.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the NHS Wales organisation commits itself to the retirement, regardless of the method of payment.

Where employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme this is disclosed. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the NHS Wales organisation's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs.

1.4.3. NEST Pension Scheme

An alternative pensions scheme for employees not eligible to join the NHS Pensions scheme has to be offered. The NEST (National Employment Savings Trust) Pension scheme is a defined contribution scheme and therefore the cost to the NHS body of participating in the scheme is equal to the contributions payable to the scheme for the accounting period.

1.5. Other expenses

Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

1.6. Property, plant and equipment

1.6.1. Recognition

Property, plant and equipment is capitalised if:

● it is held for use in delivering services or for administrative purposes;

● it is probable that future economic benefits will flow to, or service potential will be supplied to, the NHS Wales organisation;

● it is expected to be used for more than one financial year;

● the cost of the item can be measured reliably; and

● the item has cost of at least £5,000; or

● Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

● Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.6.2. Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Land and buildings used for services or for administrative purposes are stated in the Statement of Financial Position (SoFP) at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

● Land and non-specialised buildings – market value for existing use

● Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. NHS Wales' organisations have applied these new valuation requirements from 1 April 2009.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

In 2022-23 a formal revaluation exercise was applied to land and properties. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure.

References in IAS 36 to the recognition of an impairment loss of a revalued asset being treated as a revaluation decrease to the extent that the impairment does not exceed the amount in the revaluation surplus for the same asset, are adapted such that only those impairment losses that do not result from a clear consumption of economic benefit or reduction of service potential (including as a result of loss or damage resulting from normal business operations) should be taken to the revaluation reserve. Impairment losses that arise from a clear consumption of economic benefit should be taken to the Statement of Comprehensive Net Expenditure (SoCNE).

From 2015-16, IFRS 13 Fair Value Measurement must be complied with in full. However, IAS 16 and IAS 38 have been adapted for the public sector context which limits the circumstances under which a valuation is prepared under IFRS 13. Assets which are held for their service potential and are in use should be measured at their current value in existing use. For specialised assets current value in existing use should be interpreted as the present value of the assets remaining service potential, which can be assumed to be at least equal to the cost of replacing that service potential. Where there is no single class of asset that falls within IFRS 13, disclosures should be for material items only.

In accordance with the adaptation of IAS 16 in table 6.2 of the FReM, for non-specialised assets in operational use, current value in existing use is interpreted as market value for existing use which is defined in the RICS Red Book as Existing Use Value (EUV).

Assets which were most recently held for their service potential but are surplus should be valued at current value in existing use, if there are restrictions on the NHS organisation or the asset which would prevent access to the market at the reporting date. If the NHS organisation could access the market then the surplus asset should be used at fair value using IFRS 13. In determining whether such an asset which is not in use is surplus, an assessment should be made on whether there is a clear plan to bring the asset back into use as an operational asset. Where there is a clear plan, the asset is not surplus and the current value in existing use should be maintained. Otherwise the asset should be assessed as being surplus and valued under IFRS13.

Assets which are not held for their service potential should be valued in accordance with IFRS 5 or IAS 40 depending on whether the asset is actively held for sale. Where an asset is not being used to deliver services and there is no plan to bring it back into use, with no restrictions on sale, and it does not meet the IAS 40 and IFRS 5 criteria, these assets are surplus and are valued at fair value using IFRS 13.

1.6.3. Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any carrying value of the item replaced is written-out and charged to the SoCNE. As highlighted in previous years the NHS in Wales does not have systems in place to ensure that all items being "replaced" can be identified and hence the cost involved to be quantified. The NHS in Wales has thus established a national protocol to ensure it complies with the standard as far as it is able to which is outlined in the capital accounting chapter of the Manual For Accounts. This dictates that to ensure that asset carrying values are not materially overstated. For All Wales Capital Schemes that are completed in a financial year, NHS Wales organisations are required to obtain a revaluation during that year (prior to them being brought into use) and also similar revaluations are needed for all Discretionary Building Schemes completed which have a spend greater than £0.5m. The write downs so identified are then charged to operating expenses.

1.7. Intangible assets

1.7.1. Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the NHS Wales organisation; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use.
- the intention to complete the intangible asset and use it.
- the ability to use the intangible asset.
- how the intangible asset will generate probable future economic benefits.
- the availability of adequate technical, financial and other resources to complete the intangible asset and use it.
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.8. Depreciation, amortisation and impairments

Freehold land, assets under construction and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS Wales Organisation expects to obtain economic benefits or service potential from the asset. This is specific to the NHS Wales organisation and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and estimated useful lives.

At each reporting period end, the NHS Wales organisation checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

Impairment losses that do not result from a loss of economic value or service potential are taken to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to the SoCNE. Impairment losses that arise from a clear consumption of economic benefit are taken to the SoCNE. The balance on any revaluation reserve (up to the level of the impairment) to which the impairment would have been charged under IAS 36 are transferred to retained earnings.

1.9. Research and Development

Research and development expenditure is charged to operating costs in the year in which it is incurred, except insofar as it relates to a clearly defined project, which can be separated from patient care activity and benefits there from can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SoCNE on a systematic basis over the period expected to benefit from the project.

1.10 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale,within one year from the date of classification.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the SoCNE. On disposal, the balance for the asset on the revaluation reserve, is transferred to the General Fund.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead it is retained as an operational asset and its economic life adjusted. The asset is derecognised when it is scrapped or demolished.

1.11 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration.

IFRS 16 leases is effective across public sector from 1 April 2022. The transition to IFRS 16 has been completed in accordance with paragraph C5 (b) of the Standard, applying IFRS 16 requirements retrospectively recognising the cumulative effects at the date of initial application.

In the transition to IFRS 16 a number of elections and practical expedients offered in the standard have been employed. These are as follows: The entity has applied the practical expedient offered in the standard per paragraph C3 to apply IFRS 16 to contracts or arrangements previously identified as containing a lease under the previous leasing standards IAS 17 leases and IFRIC 4 determining whether an arrangement contains a lease and not to those that were identified as not containing a lease under previous leasing standards.

On initial application rhe LHB has measured the right of use assets for leases previously classified as operating leases per IFRS 16 C8 (b)(ii), at an amount equal to the lease liability adjusted for accrued or prepaid lease payments.

No adjustments have been made for operating leases in which the underlying asset is of low value per paragraph C9 (a) of the standard.

The transitional provisions have not been applied to operating leases whose terms end within 12 months of the date of initial application has been employed per paragraph C10 (c) of IFRS 16.
Hindsight is used to determine the lease term when contracts or arrangements contain options to extend or terminate the lease in accordance with C10 (e) of IFRS 16.

Due to transitional provisions employed the requirements for identifying a lease within paragraphs 9 to 11 of IFRS 16 are not employed for leases in existence at the initial date of application. Leases entered into on or after the 1st April 2022 will be assessed under the requirements of IFRS 16.
There are further expedients or election that have been employed by the LHB in applying IFRS 16.

These include:

- the measurement requirements under IFRS 16 are not applied to leases with a term of 12 months or less under paragraph 5 (a) of IFRS 16
- the measurement requirements under IFRS 16 are not applied to leases where the underlying asset is of a low value which are identified as those assets of a value of less than £5,000, excluding any irrecoverable VAT, under paragraph 5 (b) of IFRS 16

The LHB will not apply IFRS 16 to any new leases of intangible assets applying the treatment described in section 1.7 instead.

On componentisation HM Treasury have adapted the public sector approach to IFRS 16 which impacts on the identification and measurement of leasing arrangements that will be accounted for under IFRS 16.

The LHB is required to apply IFRS 16 to lease like arrangements entered into with other public sector entities that are in substance akin to an enforceable contract, that in their formal legal form may not be enforceable. Prior to accounting for such arrangements under IFRS 16 LHB has assessed that in all other respects these arrangements meet the definition of a lease under the standard.

The LHB is required to apply IFRS 16 to lease like arrangements entered into in which consideration exchanged is nil or nominal, therefore significantly below market value. These arrangements are described as peppercorn leases. Such arrangements are again required to meet the definition of a lease in every other respect prior to inclusion in the scope of IFRS 16. The accounting for peppercorn arrangements aligns to that identified for donated assets. Peppercorn leases are different in substance to arrangements in which consideration is below market value but not significantly below market value.

The nature of the accounting policy change for the lessee is more significant than for the lessor under IFRS 16. IFRS 16 introduces a singular lessee approach to measurement and classification in which lessees recognise a right of use asset.

For the lessor leases remain classified as finance leases when substantially all the risks and rewards incidental to ownership of an underlying asset are transferred to the lessee. When this transfer does not occur, leases are classified as operating leases.

1.11.1 The LHB as lessee

At the commencement date for the leasing arrangement a lessee shall recognise a right of use asset and corresponding lease liability. The entity employs a revaluation model for the subsequent measurement of its right of use assets unless cost is considered to be an appropriate proxy for current value in existing use or fair value in line with the accounting policy for owned assets. Where consideration exchanged is identified as below market value, cost is not considered to be an appropriate proxy to value the right of use asset.

Irrecoverable VAT is expensed in the period to which it relates and therefore not included in the measurement of the lease liability and consequently the value of the right of use asset.

The incremental borrowing rate of 0.95% has been applied to the lease liabilities recognised at the date of initial application of IFRS 16.

Where changes in future lease payments result from a change in an index or rate or rent review, the lease liabilities are remeasured using an unchanged discount rate.

Where there is a change in a lease term or an option to purchase the underlying asset the LHB applies a revised rate to the remaining lease liability.

Where existing leases are modified the LHB must determine whether the arrangement constitutes a separate lease and apply the standard accordingly.

Lease payments are recognised as an expense on a straight-line or another systematic basis over the lease term, where the lease term is in substance 12 months or less, or is elected as a lease containing low value underlying asset by the LHB.

1.11.2 The LHB as lessor (where relevant)

A lessor shall classify each of its leases as an operating or finance lease. A lease is classified as finance lease when the lease substantially transfers all the risks and rewards incidental to ownership of an underlying asset. Where substantially all the risks and rewards are not transferred, a lease is classified as an operating lease.

Amounts due from lessees under finance leases are recorded as receivables at the amount of [the entity] net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the the LHB net investment outstanding in respect of the leases.

Income from operating leases is recognised on a straight-line or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Where the LHB is an intermediate lessor, being a lessor and a lessee regarding the same underlying asset, classification of the sublease is required to be made by the intermediate lessor considering the term of the arrangement and the nature of the right of use asset arising from the head lease.

On transition the LHB has reassessed the classification of all of its continuing subleasing arrangements to include peppercorn leases.

1.12. Inventories

Whilst it is accounting convention for inventories to be valued at the lower of cost and net realisable value using the weighted average or "first-in first-out" cost formula, it should be recognised that the NHS is a special case in that inventories are not generally held for the intention of resale and indeed there is no market readily available where such items could be sold. Inventories are valued at cost and this is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Work-in-progress comprises goods in intermediate stages of production. Partially completed contracts for patient services are not accounted for as work-in-progress.

1.13. Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. In the Statement of Cash flows (SoCF), cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the cash management.

1.14. Provisions

Provisions are recognised when the LHB has a present legal or constructive obligation as a result of a past event, it is probable that the LHB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using the discount rate supplied by HM Treasury.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the NHS Wales organisation has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the NHS Wales organisation has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.14.1. Clinical negligence and personal injury costs

The Welsh Risk Pool Services (WRPS) operates a risk pooling scheme which is co-funded by the Welsh Government with the option to access a risk sharing agreement funded by the participative NHS Wales bodies. The risk sharing option was implemented in both 2023-24 and 2022-23. The WRP is hosted by Velindre NHS University Trust.

1.14.2. Future Liability Scheme (FLS) - General Medical Practice Indemnity (GMPI)

The FLS is a state backed scheme to provide clinical negligence General Medical Practice Indemnity (GMPI) for providers of GMP services in Wales.

In March 2019, the Minister issued a Direction to Velindre NHS Trust to enable Legal and Risk Services to operate the Scheme. The GMPI is underpinned by new secondary legislation, The NHS (Clinical Negligence Scheme) (Wales) Regulations 2019 which came into force on 1 April 2019.

GMP Service Providers are not direct members of the GMPI FLS, their qualifying liabilities are the subject of an arrangement between them and their relevant LHB, which is a member of the scheme. The qualifying reimbursements to the LHB are not subject to the £25,000 excess.

1.15. Financial Instruments

From 2018-19 IFRS 9 Financial Instruments has applied, as interpreted and adapted for the public sector, in the FReM. The principal impact of IFRS 9 adoption by NHS Wales' organisations, was to change the calculation basis for bad debt provisions, changing from an incurred loss basis to a lifetime expected credit loss (ECL) basis.

All entities applying the FReM recognised the difference between previous carrying amount and the carrying amount at the beginning of the annual reporting period that included the date of initial application in the opening general fund within Taxpayer's equity.

1.16. Financial assets

Financial assets are recognised on the SoFP when the NHS Wales organisation becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

The accounting policy choice allowed under IFRS 9 for long term trade receivables, contract assets which do contain a significant financing component (in accordance with IFRS 15), and lease receivables within the scope of IAS 17 has been withdrawn and entities should always recognise a loss allowance at an amount equal to lifetime Expected Credit Losses. All entities applying the FReM should utilise IFRS 9's simplified approach to impairment for relevant assets.

IFRS 9 requirements required a revised approach for the calculation of the bad debt provision, applying the principles of expected credit loss, using the practical expedients within IFRS 9 to construct a provision matrix.

1.16.1. Financial assets are initially recognised at fair value

Financial assets are classified into the following categories: financial assets 'at fair value through SoCNE'; 'held to maturity investments'; 'available for sale' financial assets, and 'loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.16.2. Financial assets at fair value through SoCNE

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through SoCNE. They are held at fair value, with any resultant gain or loss recognised in the SoCNE. The net gain or loss incorporates any interest earned on the financial asset.

1.16.3 Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.16.4. Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to the SoCNE on de-recognition.

1.16.5. Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the net carrying amount of the financial asset.

At the SOFP date, the LHB assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the SoCNE and the carrying amount of the asset is reduced directly, or through a provision of impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the SoCNE to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.17. Financial liabilities

Financial liabilities are recognised on the SOFP when the LHB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.17.1. Financial liabilities are initially recognised at fair value

Financial liabilities are classified as either financial liabilities at fair value through the SoCNE or other financial liabilities.

1.17.2. Financial liabilities at fair value through the SoCNE

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the SoCNE. The net gain or loss incorporates any interest earned on the financial asset.

1.17.3. Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.18. Value Added Tax (VAT)

Most of the activities of the LHB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19. Foreign currencies

Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the SoCNE. At the SoFP date, monetary items denominated in foreign currencies are retranslated at the rates prevailing at the reporting date.

1.20. Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Wales organisation has no beneficial interest in them. Details of third party assets are given in Nore 31 to the accounts.

1.21. Losses and Special Payments

Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the SoCNE on an accruals basis, including losses which would have been made good through insurance cover had the NHS Wales organisation not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses register which is prepared on a cash basis.

The LHB accounts for all losses and special payments gross (including assistance from the WRP).

The LHB accrues or provides for the best estimate of future pay-outs for certain liabilities and discloses all other potential payments as contingent liabilities, unless the probability of the liabilities becoming payable is remote.

All claims for losses and special payments are provided for, where the probability of settlement of an individual claim is over 50%. Where reliable estimates can be made, incidents of clinical negligence against which a claim has not, as yet, been received are provided in the same way. Expected reimbursements from the WRP are included in debtors. For those claims where the probability of settlement is between 5- 50%, the liability is disclosed as a contingent liability.

1.22. Pooled budget

The LHB has entered into pooled budgets with Local Authorities. Under the arrangements funds are pooled in accordance with section 33 of the NHS (Wales) Act 2006 for specific activities defined in Note 32 - the Pooled budget Note.

The pooled budget is hosted by one organisation. Payments for services provided are accounted for as miscellaneous income. The LHB accounts for its share of the assets, liabilities, income and expenditure from the activities of the pooled budget, in accordance with the pooled budget arrangement.

Monmouthshire County Council - Monnow Vale Health and Social Care Unit
Funds are pooled for the provision of health and social care inpatient, outpatient, clinic and day care facilities to individuals who have medical, social, community or rehabilitation needs. The pool is hosted by Aneurin Bevan University Local Health Board. The financial operation of the pool is governed by a pooled budget agreement between the Local Health Board and Monmouthshire County Council. The income from Monmouthshire County Council is recorded as Local Authority Income in these accounts.

Expenditure for services provided under the arrangement is recorded under the appropriate expense headings in these accounts.

The property in which the unit is housed has been provided by a Private Finance Partner; the contract with the PFI partner is for 30 years and is categorised as an on balance sheet PFI scheme with the HB recognising **72%** of the property - see Note 32 of these accounts for further details.

The five Local Authorities in Gwent - Gwent Wide Integrated Community Equipment Service
Funds are pooled for the provision of an efficient and effective GWICES (Gwent Wide Integrated Community Equipment Service) to service users who are resident in the partner localities. The pool is hosted by Torfaen County Borough Council. The Health Board makes a financial contribution to the scheme but does not account for the schemes expenditure or assets/liabilities generated by this expenditure.

The financial operation of the pool is governed by a pooled budget agreement between the bodies listed above and the Health Board. Payments for services provided by the host body, Torfaen County Borough Council, are accounted for as expenditure within these accounts.

Monmouthshire County Council - Mardy Park Rehabilitation Centre
Funds are pooled for the provision of care to individuals who have rehabilitation needs. The LHB has entered into a pooled budget with Monmouthshire County Council. The pool is hosted by Monmouthshire County Council.

The five Local Authorities in Gwent - Gwent Frailty Programme
Funds are pooled for the purpose of establishing a consistent service across Gwent. The pool is hosted by Caerphilly County Borough Council, as lead commissioner. The financial operation of the pool is governed by a pooled budget agreement between the bodies listed above and the Health Board. Payments for services provided by the host body, Caerphilly County Borough Council, are accounted for as expenditure within these accounts. Additional information is provided in Note 32.

The five Local Authorities in Gwent and ABUHB – A pooled Fund for Care Home Accommodation functions for Older People
Statutory Directions issued under section 169 of the Social Services and Wellbeing (Wales) Act 2014 required Partnership Bodies to enter into partnership arrangements and for the establishment and maintenance of pooled funds from April 2018, for the exercise of their Care Home Accommodation Functions.

The overarching strategic aim of this Agreement is: -
• To ensure coordinated arrangements for ensuring an integrated approach across the Partnership to the commissioning and arranging for Care Home Accommodation for Older People.
• To ensure provision of high quality, cost effective Care Home Accommodation which meets local health and social care needs, through the establishment of a pooled fund
• To develop a managed market approach to the supply of quality provision to meets the needs of Older People Care Home Accommodation.

Funds are pooled for the provision and commissioning of specified services for older people (>65 years of age) in a care home setting in Gwent. The pool has been hosted by Torfaen County Borough Council since August 2018.

The Health Board makes a financial contribution to the scheme equivalent to actual expenditure incurred in commissioning related placements in homes during the year, but in addition does incur minimal costs associated with a share of the services provided by the host organisation and these are accounted for as expenditure within these accounts.

1.23. Critical Accounting Judgements and key sources of estimation uncertainty

In the application of the accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources.

The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or the period of the revision and future periods if the revision affects both current and future periods.

1.24. Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the SoFP date, that have a significant risk of causing material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Significant estimations are made in relation to on-going clinical negligence and personal injury claims. Assumptions as to the likely outcome, the potential liabilities and the timings of these litigation claims are provided by independent legal advisors. Any material changes in liabilities associated with these claims would be recoverable through the Welsh Risk Pool.

Significant estimations are also made for continuing care costs resulting from claims post 1 April 2003. An assessment of likely outcomes, potential liabilities and timings of these claims are made on a case by case basis. Material changes associated with these claims would be adjusted in the period in which they are revised.

Estimates are also made for contracted primary care services. These estimates are based on the latest payment levels. Changes associated with these liabilities are adjusted in the following reporting period.

1.24.1. Provisions

The LHB provides for legal or constructive obligations for clinical negligence, personal injury and defence costs that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation.

Claims are funded via the Welsh Risk Pool Services (WRPS) which receives an annual allocation from Welsh Government to cover the cost of reimbursement requests submitted to the bi-monthly WRPS Committee. Following settlement to individual claimants by the NHS Wales organisation, the full cost is recognised in year and matched to income (less a £25K excess) via a WRPS debtor, until reimbursement has been received from the WRPS Committee.

1.24.2. Probable & Certain Cases – Accounting Treatment

A provision for these cases is calculated in accordance with IAS 37. Cases are assessed and divided into four categories according to their probability of settlement;

Remote	Probability of Settlement	0 – 5%
	Accounting Treatment	Remote Contingent Liability.
Possible	Probability of Settlement	6% - 49%
	Accounting Treatment	Defence Fee - Provision*
	Contingent Liability for all other estimated expenditure.	
Probable	Probability of Settlement	50% - 94%
	Accounting Treatment	Full Provision
Certain	Probability of Settlement	95% - 100%
	Accounting Treatment	Full Provision

** Personal injury cases - Defence fee costs are provided for at 100%.*

The provision for probable and certain cases is based on case estimates of individual reported claims received by Legal & Risk Services within NHS Wales Shared Services Partnership.

The solicitor will estimate the case value including defence fees, using professional judgement and from obtaining counsel advice. Valuations are then discounted for the future loss elements using individual life expectancies and the Government Actuary's Department actuarial tables (Ogden tables) and Personal Injury Discount Rate of minus 0.25%.

Future liabilities for certain & probable cases with a probability of 95%-100% and 50%- 94% respectively are held as a provision on the balance sheet. Cases typically take a number of years to settle, particularly for high value cases where a period of development is necessary to establish the full extent of the injury caused.

The Health Board has provided for some £213m (£162m 2022/23) within note 20 in respect of potential clinical negligence and personal injury claims and associated defence fees. These provisions have been arrived at on the advice of NHS Wales Shared Services Partnership - Legal & Risk Services. Given the nature of such claims this figure could be subject to significant change in future periods. However, the potential financial effect of such uncertainty is mitigated by the fact that the LHB's ultimate liability in respect of individual cases is capped at £0.025m, with amounts above this excess level being reimbursed by the Welsh Risk Pool.

The Health Board has estimated a liability of £0.393m (£0.427m 2022/23) in respect of retrospective claims for Continuing Health Care funding. The estimated provision is based upon an assessment of the likelihood of claims meeting criteria for continuing health care and the actual costs incurred by individuals in care homes. The provision is based on information made available to the Health Board at the time of these accounts and could be subject to significant change as outcomes are determined.

Aneurin Bevan University Local Health Board has reviewed its portfolio of outstanding claims for continuing healthcare and made an assessment of likely financial liability based on an estimated success factor, eligibility factor and expected weekly average costs of claims. The assumptions have been derived by reviewing a sample of claims.

Primary care expenditure includes estimates for areas which are paid in arrears and not finalised at the time of producing the accounts. These estimates relate to GMS Quality Assurance and Improvement Framework, GMS Enhanced Services, and pharmacy estimates, which are based on an assessment of likely final performance.

1.25 Discount Rates

Where discount is applied, a disclosure detailing the impact of the discounting on liabilities to be included for the relevant notes. The disclosure should include where possible undiscounted values to demonstrate the impact. An explanation of the source of the discount rate or how the discount rate has been determined to be included.

Within the Provisions Note (note 20) the amount relating to Early Retirements and Permanent Injury benefits has been discounted using the PES (2021) Post Employment Benefits Liabilities Real Rate in Excess of CPI of 2.45%.

1.26 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The LHB therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;

b) Payment for the PFI asset, including finance costs; and

c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.26.1. Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.26.2. PFI asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the NHS Wales organisation's approach for each relevant class of asset in accordance with the principles of IAS 16.

1.26.2. PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the SoCNE.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the SoCNE.

1.26.3. Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the NHS Wales organisation's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.26.4. Assets contributed by the NHS Wales organisation to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the LHBs SoFP.

1.26.5. Other assets contributed by the NHS Wales organisation to the operator

Assets contributed (e.g. cash payments, surplus property) by the LHB to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the LHB, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured at the present value of the minimum lease payments, discounted using the implicit interest rate. It is subsequently measured as a finance lease liability in accordance with IAS 17.

On initial recognition of the asset, the difference between the fair value of the asset and the initial liability is recognised as deferred income, representing the future service potential to be received by the NHS Wales organisation through the asset being made available to third party users.

Other PFI arrangements off Statement of Financial Position
The LHB has one PFI Scheme that was previously classified as off-statement of financial position. The scheme related to the provision of replacement heating and lighting systems within Nevill Hall hospital. The scheme commenced in 2000 for a period of 25 years. Since the introduction of IFRS 16 in 2022/23, the off-statement of Financial Position PFI has been recognised as a Right of use Asset.

Joint PFI contract
The LHB has entered into an agreement to share a facility, provided by a Private Finance Partner, with Monmouthshire County Council to match the agreement with the Private Finance Partner. The arrangement is treated as a PFI arrangement and the total obligation is included as a liability of the LHB. The contribution towards the unitary charge committed by Monmouthshire County Council is treated as a financial asset. The future contribution was measured initially at the same amount as the fair value of the share of the PFI asset and is subsequently measured as a finance lease.

1.26.6 Impact of IFRS 16 on on-balance sheet PFI/PPP Schemes

On-balance sheet PPP arrangements should be based on IFRS 16 accounting principles from 2023/24.

When measuring the liability for on-balance sheet PPP contracts containing capital payments linked to a price index IFRS 16 requires that 'a lessee shall remeasure the lease liability where there is a change in future lease payments resulting from a change in an index or a rate used to determine those payments. The lessee shall remeasure the lease liability to reflect those revised lease payments only when there is a change in the cash flows.

Initial remeasurement -the future PPP liability will need to be remeasured at 1 April 2023 to include the actual indexation-linked changes to payments for the capital/infrastructure element which have taken effect in the cash flows since the PPP agreement commenced. This should use a cumulative catch-up approach, where the cumulative effect is recognised as an adjustment to the opening balance of retained earnings.

Subsequent measurement - The PPP liability will continue to require remeasurements whenever cash payments change in response to indexation movements as set out in the individual PPP contract. The double entry for the subsequent liability remeasurement should be Debit Finance Cost, Credit PPP liability.

The liability does not include estimated future indexation linked increases.

1.27. Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the LHB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the LHB. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

Remote contingent liabilities are those that are disclosed under Parliamentary reporting requirements and not under IAS 37 and, where practical, an estimate of their financial effect is required.

1.28. Absorption accounting

Transfers of function are accounted for as either by merger or by absorption accounting dependent upon the treatment prescribed in the FReM. Absorption accounting requires that entities account for their transactions in the period in which they took place with no restatement of performance required.

Where transfer of function is between LHBs the gain or loss resulting from the assets and liabilities transferring is recognised in the SoCNE and is disclosed separately from the operating costs.

1.29. Accounting standards that have been issued but not yet been adopted

The following accounting standards have been issued and or amended by the IASB and IFRIC but have not been adopted because they are not yet required to be adopted by the FReM

IFRS14 Regulatory Deferral Accounts
Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable.

IFRS 17 Insurance Contracts, Application required for accounting periods beginning on or after 1 January 2023, Standard is not yet adopted by the FReM which is expected to be from April 2025: early adoption is not permitted.

1.30. Accounting standards issued that have been adopted early

During 2023-24 there have been no accounting standards that have been adopted early. All early adoption of accounting standards will be led by HM Treasury.

1.31. Charities

Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the LHB has established that as it is the corporate trustee of the Aneurin Bevan University LHB NHS Charitable Fund, it is considered for accounting standards compliance to have control of the Aneurin Bevan University LHB NHS Charitable Fund as a subsidiary and therefore is required to consolidate the results of the Aneurin Bevan University LHB NHS Charitable Fund within the statutory accounts of the LHB.

The determination of control is an accounting standard test of control and there has been no change to the operation of the Aneurin Bevan University LHB NHS Charitable Fund or its independence in its management of charitable funds.

However, the LHB organisation has with the agreement of the Welsh Government adopted the IAS 27 (10) exemption to consolidate. Welsh Government as the ultimate parent of the Local Health Boards will disclose the Charitable Accounts of Local Health Boards in the Welsh Government Consolidated Accounts.

Details of the transactions with the charity are included in the related parties' notes - note 30.

2. Financial Duties Performance

The National Health Service Finance (Wales) Act 2014 came into effect from 1 April 2014. The Act amended the financial duties of Local Health Boards under section 175 of the National Health Service (Wales) Act 2006. From 1 April 2014 section 175 of the National Health Service (Wales) Act places two financial duties on Local Health Boards:

- A duty under section 175 (1) to secure that its expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years
- A duty under section 175 (2A) to prepare a plan in accordance with planning directions issued by the Welsh Ministers, to secure compliance with the duty under section 175 (1) while improving the health of the people for whom it is responsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.

The first assessment of performance against the 3 year statutory duty under section 175 (1) was at the end of 2016-17, being the first 3 year period of assessment.

Welsh Health Circular WHC/2016/054 "Statutory and Financial Duties of Local Health Boards and NHS Trusts" clarifies the statutory financial duties of NHS Wales bodies effective from 2016-17.

2.1 Revenue Resource Performance

Annual financial performance

	2021-22	2022-23	2023-24	**Total**
	£000	£000	£000	**£000**
Net operating costs for the year	1,598,803	1,676,282	1,818,456	**5,093,541**
Less general ophthalmic services expenditure and other non-cash limited expenditure	(58)	148	599	**689**
Less unfunded revenue consequences of bringing PFI schemes onto SoFP	0	0	29	**29**
Total operating expenses	1,598,745	1,676,430	1,819,084	**5,094,259**
Revenue Resource Allocation	1,598,994	1,639,588	1,769,330	**5,007,912**
Under /(over) spend against Allocation	249	(36,842)	(49,754)	**(86,347)**

Aneurin Bevan University LHB has not met its financial duty to break-even against its Revenue Resource Limit over the 3 years 2021-22 to 2023-24.
The Health Board will, in dialogue with Welsh Government, confirm the implications for reporting this deficit as part of the 2024/25 IMTP.
The health board received £49.9m of strategic cash support in 2023/24.

2.2 Capital Resource Performance

	2021-22	2022-23	2023-24	**Total**
	£000	£000	£000	**£000**
Gross capital expenditure	52,167	41,028	62,681	**155,876**
Add: Losses on disposal of donated assets	0	2	1	**3**
Less NBV of property, plant and equipment, right of use and intangible assets	(3,115)	(61)	(5,845)	**(9,021)**
Less capital grants received	(22)	(62)	0	**(84)**
Less donations received	(166)	(227)	(136)	**(529)**
Less IFRS16 Peppercorn income	0	0	0	**0**
Less **initial recognition** of RoU Asset Dilapidations	0	0	0	**0**
Charge against Capital Resource Allocation	48,864	40,680	56,701	**146,245**
Capital Resource Allocation	48,914	40,723	56,742	**146,379**
(Over) / Underspend against Capital Resource Allocation	50	43	41	**134**

Aneurin Bevan University LHB has met its financial duty to break-even against its Capital Resource Limit over the 3 years 2021-22 to 2023-24.

2.3 Duty to prepare a 3 year integrated plan

The NHS Wales Planning Framework for the period 2022-2025 issued to LHBs placed a requirement upon them to prepare and submit Integrated Medium Term Plans to the Welsh Government.

The LHB was unable to submit a balanced Integrated Medium Term Plan for the period 2023-2026 in accordance with NHS Wales Planning Framework. The Health Board submitted an Annual Plan for 2023-24: Three Year Intent 2024/25 and were placed in targeted intervention with a requirement for the Health Board to deliver the commitments set out in the annual plan.

The Minister for Health and Social Services extant approval	
Status	**Approved**
Date	

The LHB has therefore not met its statutory duty to have an approved Integrated Medium Term plan.

2.4 Creditor payment

The LHB is required to pay 95% of the number of non-NHS bills within 30 days of receipt of goods or a valid invoice (whichever is the later). The LHB has achieved the following results:

	2023-24	2022-23
Total number of non-NHS bills paid	**327,881**	371,943
Total number of non-NHS bills paid within target	**319,291**	354,020
Percentage of non-NHS bills paid within target	97.4%	95.2%

The LHB has met the target.

3. Analysis of gross operating costs

3.1 Expenditure on Primary Healthcare Services

	Cash limited	Non-cash limited	2023-24 Total	2022-23 Total
	£000	£000	£000	£000
General Medical Services	122,671		122,671	116,217
Pharmaceutical Services	33,813	(8,057)	25,756	25,273
General Dental Services	39,870		39,870	39,817
General Ophthalmic Services	3,201	7,458	10,659	8,866
Other Primary Health Care expenditure	4,373		4,373	2,612
Prescribed drugs and appliances	121,947		121,947	114,331
Total	**325,875**	**(599)**	**325,276**	307,116

Note 3.1 - Expenditure on Primary Healthcare Services
The General Medical Services expenditure includes £18,793k (2022/23 £16,406k) in relation to staff salaries, the General Dental Services expenditure includes £4,070k (2022/23 £3,032k) in relation to staff salaries, the Prescribed Drugs & Appliance expenditure includes £348k (2022/23 £329k) in relation to staff salaries, and the General Ophthalmic Services includes £37k (2022/23 £8k) in relation to staff salaries.

3.2 Expenditure on healthcare from other providers

	2023-24	2022-23
	£000	£000
Goods and services from other NHS Wales Health Boards	**69,753**	63,968
Goods and services from other NHS Wales Trusts	**47,460**	43,527
Goods and services from Welsh Special Health Authorities	**0**	0
Goods and services from other non Welsh NHS bodies	**12,041**	10,092
Goods and services from WHSSC / EASC	**208,640**	198,320
Local Authorities	**41,143**	47,685
Voluntary organisations	**9,408**	9,260
NHS Funded Nursing Care	**11,260**	9,681
Continuing Care	**99,136**	86,006
Private providers	**9,110**	5,392
Specific projects funded by the Welsh Government	**0**	0
Other	**447**	222
Total	**508,398**	474,153

Local Authorities expenditure relates to the following bodies:	**£'000**	£'000
Blaenau Gwenty County Borough Council	**3,462**	4,331
Caerphilly County Borough Council	**17,706**	17,867
Monmouthshire County Council	**4,759**	8,334
Newport City Council	**8,289**	10,252
Torfaen County Borough Council	**6,874**	6,790
Gloucestershire County Council	**52**	111
Swansea Council	**1**	0
Swindon Borough Council	**0**	0
	41,143	47,685

3.3 Expenditure on Hospital and Community Health Services

	2023-24	2022-23
	£000	£000
Directors' costs	2,206	2,374
Operational Staff costs	786,497	729,603
Single lead employer Staff Trainee Cost	32,482	30,104
Collaborative Bank Staff Cost	0	0
Supplies and services - clinical	130,717	120,657
Supplies and services - general	20,384	20,123
Consultancy Services	410	327
Establishment	7,251	6,928
Transport	1,441	1,942
Premises	43,954	48,310
External Contractors	0	0
Depreciation	43,001	42,936
Depreciation Right of Use assets (RoU)	4,474	4,479
Amortisation	2,349	2,859
Fixed asset impairments and reversals (Property, plant & equipment)	9,732	(19,470)
Fixed asset impairments and reversals (RoU Assets)	0	0
Fixed asset impairments and reversals (Intangible assets)	438	0
Impairments & reversals of financial assets	0	0
Impairments & reversals of non-current assets held for sale	0	0
Audit fees	455	421
Other auditors' remuneration	0	0
Losses, special payments and irrecoverable debts	3,217	1,526
Research and Development	0	0
Expense related to short-term leases	713	552
Expense related to low-value asset leases (excluding short-term leases)	936	858
Other operating expenses	14,599	9,538
Total	**1,105,256**	1,004,067

The Health Board spent £2.9m (£2.7m 2022/23) on Research and Development. The majority of this spend relates to staff £2.3m (£2.2m 2022/23) which along with the non-staff spend is reflected under the various headings within note 3.3. During 2023-24 Research and Development income received was £2.7m (£2.6m 2022/23).

3.4 Losses, special payments and irrecoverable debts: charges to operating expenses

Increase/(decrease) in provision for future payments:	2023-24 £000	2022-23 £000
Clinical negligence;		
Secondary care	**72,303**	(3,578)
Primary care	**817**	38
Redress Secondary Care	**221**	478
Redress Primary Care	**0**	0
Personal injury	**734**	193
All other losses and special payments	**821**	34
Defence legal fees and other administrative costs	**1,308**	1,184
Gross increase/(decrease) in provision for future payments	**76,204**	**(1,651)**
Contribution to Welsh Risk Pool	**0**	0
Premium for other insurance arrangements	**0**	0
Irrecoverable debts	**198**	(104)
Less: income received/due from Welsh Risk Pool	**(72,845)**	3,281
Total	**3,557**	1,526

	2023-24 £	2022-23 £
Permanent injury included within personal injury £:	**(613,210)**	(285,049)

Note 3.4 includes £563,791 (£615,848 2022/23) relating to Redress cases which represents 81 (81 2022/23) cases where payments were made in year totalling £293,446 (£275,664 2022/23) including defence fees. An additional provision has been created for a further 33 (50 2022/23) cases where an offer has been made or causation and breach have been proven with estimated costs of £269,845 (£340,184 2022/23).

During 2023/24 ABUHB incurred a loss of £756,007.34 as a result of flood damage. £416,135.83 related to revenue items with £339,871.50 relating to capital items. This has resulted in a variance between Note 3.3 and Note 3.4 as the Capital loss of £339,891.50 is reflected within the SoCNE page 2 row 18 - Other (Gains)/Losses.

4. Miscellaneous Income

	2023-24	2022-23
	£000	£000
Local Health Boards	**22,054**	20,509
Welsh Health Specialised Services Committee (WHSSC)/Emergency Ambulance Services Committee (EASC)	**13,948**	11,521
NHS Wales trusts	**11,418**	10,652
Welsh Special Health Authorities	**15,800**	13,782
Foundation Trusts	**38**	22
Other NHS England bodies	**1,472**	1,469
Other NHS Bodies	**56**	58
Local authorities	**20,351**	19,078
Welsh Government	**6,792**	4,622
Welsh Government Hosted bodies	**0**	0
Non NHS:		
Prescription charge income	**0**	0
Dental fee income	**5,160**	4,848
Private patient income	**0**	27
Overseas patients (non-reciprocal)	**157**	42
Injury Costs Recovery (ICR) Scheme	**1,140**	1,022
Other income from activities	**1,083**	837
Patient transport services	**0**	0
Education, training and research	**30**	2,043
Charitable and other contributions to expenditure	**1,259**	1,048
Receipt of NWSSP Covid centrally purchased assets	**0**	0
Receipt of Covid centrally purchased assets from other organisations	**0**	0
Receipt of donated assets	**136**	210
Receipt of Government granted assets	**0**	62
Right of Use Grant (Peppercorn Lease)	**0**	17
Non-patient care income generation schemes	**131**	100
NHS Wales Shared Services Partnership (NWSSP)	**0**	0
Deferred income released to revenue	**0**	0
Right of Use Asset Sub-leasing rental income	**0**	0
Contingent rental income from finance leases	**0**	0
Rental income from operating leases	**343**	226
Other income:		
Provision of laundry, pathology, payroll services	**131**	102
Accommodation and catering charges	**3,519**	3,103
Mortuary fees	**364**	375
Staff payments for use of cars	**625**	617
Business Unit	**0**	0
Scheme Pays Reimbursement Notional	**463**	(615)
Other	**15,486**	13,789
Total	**121,956**	109,566

Other income Includes;		
Salary Sacrifice Schemes & Fleet Vehicles	**5,954**	4,265
VAT recoveries re Business Activities and Contracted Out Services	**2,249**	1,523
Integrated Care Fund	**3,678**	4,894
Other	**3,605**	3,107
	0	0
	0	0
	0	0
Total	**15,486**	13,789

Injury Cost Recovery (ICR) Scheme income

	2023-24	2022-23
	%	%
To reflect expected rates of collection ICR income is subject to a provision for impairment of:	23.07	24.86

5. Investment Revenue

	2023-24 £000	2022-23 £000
Rental revenue :		
PFI Finance lease income		
planned	**0**	0
contingent	**0**	0
Other finance lease revenue	**0**	0
Interest revenue :		
Bank accounts	**0**	0
Other loans and receivables	**0**	0
Impaired financial assets	**0**	0
Other financial assets	**17**	18
Total	**17**	18

6. Other gains and losses

	2023-24 £000	2022-23 £000
Gain/(loss) on disposal of property, plant and equipment	**(345)**	530
Gain/(loss) on disposal other than by sale of right of use assets assets	**14**	0
Gain/(loss) on disposal of intangible assets	**0**	0
Gain/(loss) on disposal of assets held for sale	**0**	0
Gain/(loss) on disposal of financial assets	**0**	0
Change on foreign exchange	**0**	0
Change in fair value of financial assets at fair value through SoCNE	**0**	0
Change in fair value of financial liabilities at fair value through SoCNE	**0**	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	**0**	0
Total	**(331)**	530

7. Finance costs

	2023-24 £000	2022-23 £000
Interest on loans and overdrafts	**0**	0
Interest on obligations under finance leases	**0**	0
Interest on obligations under Right of Use Leases	**274**	232
Interest on obligations under PFI contracts;		
main finance cost	**231**	239
contingent finance cost	**0**	471
Impact of IFRS 16 on PPP/PFI contracts	**521**	0
Interest on late payment of commercial debt	**0**	0
Other interest expense	**0**	0
Total interest expense	**1,026**	942
Provisions unwinding of discount	**142**	118
Other finance costs	**0**	0
Total	**1,168**	1,060

8. Future change to SoCNE/Operating Leases

LHB as lessee

As at 31st March 2024 the LHB had 2 operating leases agreements in place for the lease of premises, 510 arrangements in respect of equipment and 242 in respect of vehicles with 3 property, 195 equipment and 70 vehicle leases having expired in year.

	2023-24	2023-24	2023-24	2022-23
	Low Value & Short Term	Other	Total	Total
Payments recognised as an expense				
	£000	**£000**	**£000**	£000
Minimum lease payments	**1,670**	**0**	**1,670**	1,487
Contingent rents	**0**	**0**	**0**	0
Sub-lease payments	**0**	**0**	**0**	0
Total	**1,670**	**0**	**1,670**	1,487

Total future minimum lease payments		
Payable	**£000**	£000
Not later than one year	**1,079**	864
Between one and five years	**862**	612
After 5 years	**0**	0
Total	**1,941**	1,476

LHB as lessor

	2023-24	2022-23
Rental revenue	**£000**	£000
Rent	**343**	226
Contingent rents	**0**	0
Total revenue rental	**343**	226

Total future minimum lease payments		
Receivable	**£000**	£000
Not later than one year	**289**	252
Between one and five years	**1,033**	964
After 5 years	**1,031**	1,236
Total	**2,353**	2,452

9. Employee benefits and staff numbers

9.1 Employee costs

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Collaborative Bank Staff	Other	Total	2022-23
	£000	£000	£000	£000	£000	£000	£000	£000
Salaries and wages	**603,287**	**1,504**	**39,562**	**25,864**	**0**	**2,766**	**672,983**	627,009
Social security costs	**63,758**	**0**	**0**	**3,133**	**0**	**0**	**66,891**	62,249
Employer contributions to NHS Pension Scheme	**101,724**	**0**	**0**	**3,485**	**0**	**0**	**105,209**	93,244
Other pension costs	**298**	**0**	**0**	**0**	**0**	**0**	**298**	365
Other employment benefits	**0**	**0**	**0**	**0**	**0**	**0**	**0**	0
Termination benefits	**0**	**0**	**0**	**0**	**0**	**0**	**0**	0
Total	**769,067**	**1,504**	**39,562**	**32,482**	**0**	**2,766**	**845,381**	782,867

Charged to capital	**977**	1,011
Charged to revenue	**844,404**	781,856
	845,381	782,867
Net movement in accrued employee benefits (untaken staff leave)	**(167)**	(12)

The staff under the 'Other' heading relate to Agency Medical Staff who are paid via a direct engagement scheme which commenced in January 2020.

9.2 Average number of employees

	Permanent Staff Number	Staff on Inward Secondment Number	Agency Staff Number	Specialist Trainee (SLE) Number	Collaborative Bank Staff Number	Other Number	Total Number	2022-23 Number
Administrative, clerical and board members	**2,743**	**12**	**6**	**0**	**0**	**0**	**2,761**	2,727
Medical and dental	**839**	**8**	**73**	**404**	**0**	**14**	**1,338**	1,259
Nursing, midwifery registered	**3,815**	**1**	**196**	**0**	**0**	**0**	**4,012**	3,991
Professional, Scientific, and technical staff	**449**	**0**	**3**	**0**	**0**	**0**	**452**	462
Additional Clinical Services	**2,804**	**0**	**37**	**0**	**0**	**0**	**2,841**	2,877
Allied Health Professions	**857**	**0**	**19**	**0**	**0**	**0**	**876**	829
Healthcare Scientists	**242**	**0**	**5**	**0**	**0**	**0**	**247**	245
Estates and Ancilliary	**995**	**0**	**98**	**0**	**0**	**0**	**1,093**	1,146
Students	**9**	**0**	**0**	**0**	**0**	**0**	**9**	10
Total	**12,753**	**21**	**437**	**404**	**0**	**14**	**13,629**	13,546

9.3. Retirements due to ill-health

	2023-24	2022-24
Number	**15**	14
Estimated additional pension costs £	**1,462,604**	606,310

The estimated additional pension costs of these ill-health retirements have been calculated on an average basis and are borne by the NHS Pension Scheme.

9.4 Employee benefits

The Health Board does not have an employee benefit scheme.

9.5 Reporting of other compensation schemes - exit packages

Exit packages cost band (including any special payment element)	2023-24 Number of compulsory redundancies	2023-24 Number of other departures	2023-24 Total number of exit packages	2023-24 Number of departures where special payments have been made	2022-23 Total number of exit packages
	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only
less than £10,000	0	0	0	0	0
£10,000 to £25,000	0	0	0	0	0
£25,000 to £50,000	0	0	0	0	1
£50,000 to £100,000	0	0	0	0	0
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	0	0	0	1

Exit packages cost band (including any special payment element)	2023-24 Cost of compulsory redundancies	2023-24 Cost of other departures	2023-24 Total cost of exit packages	2023-24 Cost of special element included in exit packages	2022-23 Total cost of exit packages
	£	£	£	£	£
less than £10,000	0	0	0	0	0
£10,000 to £25,000	0	0	0	0	0
£25,000 to £50,000	0	0	0	0	32,197
£50,000 to £100,000	0	0	0	0	0
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	0	0	0	32,197

Exit costs paid in year of departure	Total paid in year 2023-24	Total paid in year 2022-23
	£	£
Exit costs paid in year	0	0
Total	0	0

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Voluntary Early Release Scheme (VERS).

Where the LHB has agreed early retirements, the additional costs are met by the LHB and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

The Health Board has not approved any VERS in 2023-24.
Additional requirement as per FReM
£0.00 exit costs were paid in 2023-24, relating to 2022-23 (the year of departure).

9.6 Fair Pay disclosures

9.6.1 Remuneration Relationship

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/employee in their organisation and the 25th percentile, median and 75th percentile remuneration of the organisation's workforce.

	2023-24	**2023-24**	**2023-24**	2022-23	2022-23	2022-23
	£000	**£000**	**£000**	£000	£000	£000
Total pay and benefits	**Chief Executive**	**Employee**	**Ratio**	Chief Executive	Employee	Ratio
25th percentile pay ratio	**225 - 230**	**29**	**8.0**	215 - 220	26	8.3
Median pay	**225 - 230**	**36**	**6.3**	215 - 220	33	6.5
75th percentile pay ratio	**225 - 230**	**47**	**4.9**	215 - 220	43	5.0
Salary component of total pay and benefits						
25th percentile pay ratio	**225 - 230**	**29**		215 - 220	26	
Median pay	**225 - 230**	**36**		215 - 220	33	
75th percentile pay ratio	**225 - 230**	**47**		215 - 220	43	

	Highest Paid			Highest Paid		
Total pay and benefits	**Director**	**Employee**	**Ratio**	Director	Employee	Ratio
25th percentile pay ratio	**225 - 230**	**29**	**8.0**	215 - 220	26	8.3
Median pay	**225 - 230**	**36**	**6.3**	215 - 220	33	6.5
75th percentile pay ratio	**225 - 230**	**47**	**4.9**	215 - 220	43	5.0
Salary component of total pay and benefits						
25th percentile pay ratio	**225 - 230**	**29**		215 - 220	26	
Median pay	**225 - 230**	**36**		215 - 220	33	
75th percentile pay ratio	**225 - 230**	**47**		215 - 220	43	

In 2023-24, 10 (2022-23, 15) employees received remuneration in excess of the highest-paid director.

Remuneration for all staff ranged from £15k to £383k (2022-23, £14k to £416k).

The all staff range includes directors (including the highest paid director) and excludes pension benefits of all employees.

Financial year summary

There has been an decrease in the pay ratio which attributable to the increase in the chief exectuive / highest paid director salary being less than the increase in the employee median salary.

The median pay ratio for the relevant financial year is consistent with the pay, reward and progression policies for the entity's employees taken as a whole.

9.6.2 Percentage Changes

	2022-23 to 2023-24	2021-22 to 2022-23
	%	**%**
% Change from previous financial year in respect of Chief Executive		
Salary and allowances	**5**	7
Performance pay and bonuses	**0**	0
% Change from previous financial year in respect of highest paid director		
Salary and allowances	**5**	7
Performance pay and bonuses	**0**	0
Average % Change from previous financial year in respect of employees takes as a whole		
Salary and allowances	**7**	5
Performance pay and bonuses	**0**	0

9.7 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years".
An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2024, is based on valuation data as 31 March 2023, updated to 31 March 2024 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

c) National Employment Savings Trust (NEST)

NEST is a workplace pension scheme, which was set up by legislation and is treated as a trust-based scheme. The Trustee responsible for running the scheme is NEST Corporation. It's a non-departmental public body (NDPB) that operates at arm's length from government and is accountable to Parliament through the Department for Work and Pensions (DWP).

NEST Corporation has agreed a loan with the Department for Work and Pensions (DWP). This has paid for the scheme to be set up and will cover expected shortfalls in scheme costs during the earlier years while membership is growing.

NEST Corporation aims for the scheme to become self-financing while providing consistently low charges to members.

Using qualifying earnings to calculate contributions, currently the legal minimum level of contributions is 8% of a jobholder's qualifying earnings, for employers whose legal duties have started. The employer must pay at least 3% of this.

The earnings band used to calculate minimum contributions under existing legislation is called qualifying earnings. Qualifying earnings are currently those between £6,240 and £50,270 for the 2023-24 tax year (2022-23 £6,240 and £50,270).

Restrictions on the annual contribution limits were removed on 1st April 2017.

10. Public Sector Payment Policy - Measure of Compliance

10.1 Prompt payment code - measure of compliance

The Welsh Government requires that Health Boards pay all their trade creditors in accordance with the CBI prompt payment code and Government Accounting rules. The Welsh Government has set as part of the Health Board financial targets a requirement to pay 95% of the number of non-NHS creditors within 30 days of delivery.

	2023-24	**2023-24**	2022-23	2022-23
NHS	**Number**	**£000**	Number	£000
Total bills paid	4,932	402,257	4,740	380,000
Total bills paid within target	4,364	381,217	4,198	360,894
Percentage of bills paid within target	**88.5%**	**94.8%**	88.6%	95.0%
Non-NHS				
Total bills paid	327,881	709,739	371,943	651,605
Total bills paid within target	319,291	688,084	354,020	624,146
Percentage of bills paid within target	**97.4%**	**96.9%**	95.2%	95.8%
Total				
Total bills paid	**332,813**	**1,111,996**	376,683	1,031,605
Total bills paid within target	**323,655**	**1,069,301**	358,218	985,040
Percentage of bills paid within target	**97.2%**	**96.2%**	95.1%	95.5%

10.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2023-24	2022-23
	£	£
Amounts included within finance costs (note 7) from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**542**	413
Total	**542**	**413**

11.1 Property, plant and equipment

2023-24

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost at 31 March bf	77,508	696,196	2,237	36,936	118,190	546	43,310	4,162	979,085
NHS Wales Transfers	0	0	0	0	0	0	0	0	0
Prepayments	0	0	0	0	0	0	0	0	0
Transfer of Finance Leases to ROU Asset Note	0	0	0	0	0	0	0	0	0
Cost or valuation at 1 April 2023	**77,508**	**696,196**	**2,237**	**36,936**	**118,190**	**546**	**43,310**	**4,162**	**979,085**
Indexation	**(2,000)**	**21,643**	**33**	**0**	**0**	**0**	**0**	**0**	**19,676**
Additions									
- purchased	**0**	**2,574**	**19**	**46,443**	**5,806**	**0**	**2,471**	**243**	**57,556**
- donated	**0**	**0**	**0**	**0**	**136**	**0**	**0**	**0**	**136**
- government granted	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Transfer from/into other NHS bodies	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	**0**	**42,054**	**0**	**(42,602)**	**124**	**0**	**250**	**(410)**	**(584)**
Revaluations	**0**	**(22)**	**0**	**0**	**0**	**0**	**0**	**0**	**(22)**
Reversal of impairments	**0**	**19,893**	**101**	**0**	**0**	**0**	**0**	**0**	**19,994**
Impairments	**(397)**	**(31,439)**	**0**	**0**	**0**	**0**	**0**	**0**	**(31,836)**
Reclassified as held for sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disposals	**0**	**0**	**0**	**0**	**(7,193)**	**(265)**	**(6,573)**	**(42)**	**(14,073)**
At 31 March 2024	**75,111**	**750,899**	**2,390**	**40,777**	**117,063**	**281**	**39,458**	**3,953**	**1,029,932**
Depreciation at 31 March bf	0	22,122	294	0	60,999	502	24,324	1,303	**109,544**
NHS Wales Transfers	0	0	0	0	0	0	0	0	**0**
Transfer of Finance Leases to ROU Asset Note	0	0	0	0	0	0	0	0	**0**
Depreciation at 1 April 2023	**0**	**22,122**	**294**	**0**	**60,999**	**502**	**24,324**	**1,303**	**109,544**
Indexation	**0**	**879**	**15**	**0**	**0**	**0**	**0**	**0**	**894**
Transfer from/into other NHS bodies	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	**0**	**0**	**0**	**0**	**(2)**	**0**	**79**	**(112)**	**(35)**
Revaluations	**0**	**(657)**	**0**	**0**	**0**	**0**	**0**	**0**	**(657)**
Reversal of impairments	**0**	**439**	**3**	**0**	**0**	**0**	**0**	**0**	**442**
Impairments	**0**	**(2,552)**	**0**	**0**	**0**	**0**	**0**	**0**	**(2,552)**
Reclassified as held for sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disposals	**0**	**0**	**0**	**0**	**(6,642)**	**(265)**	**(6,573)**	**(42)**	**(13,522)**
Provided during the year	**0**	**22,912**	**83**	**0**	**12,921**	**32**	**6,678**	**375**	**43,001**
At 31 March 2024	**0**	**43,143**	**395**	**0**	**67,276**	**269**	**24,508**	**1,524**	**137,115**
Net book value at 1 April 2023	**77,508**	**674,074**	**1,943**	**36,936**	**57,191**	**44**	**18,986**	**2,859**	**869,541**
Net book value at 31 March 2024	**75,111**	**707,756**	**1,995**	**40,777**	**49,787**	**12**	**14,950**	**2,429**	**892,817**
Net book value at 31 March 2024 comprises :									
Purchased	**72,053**	**705,809**	**1,995**	**40,777**	**49,031**	**12**	**14,879**	**2,393**	**886,949**
Donated	**3,058**	**1,745**	**0**	**0**	**560**	**0**	**71**	**36**	**5,470**
Government Granted	**0**	**202**	**0**	**0**	**196**	**0**	**0**	**0**	**398**
At 31 March 2024	**75,111**	**707,756**	**1,995**	**40,777**	**49,787**	**12**	**14,950**	**2,429**	**892,817**
Asset financing :									
Owned	**75,111**	**703,130**	**1,995**	**40,777**	**49,759**	**12**	**14,950**	**2,429**	**888,163**
On-SoFP MIMS Funded PPP contracts	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
On-SoFP PFI contracts	**0**	**4,626**	**0**	**0**	**28**	**0**	**0**	**0**	**4,654**
PFI residual interests	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
At 31 March 2024	**75,111**	**707,756**	**1,995**	**40,777**	**49,787**	**12**	**14,950**	**2,429**	**892,817**

The net book value of land, buildings and dwellings at 31 March 2024 comprises :

	£000
Freehold	**780,060**
Long Leasehold	**4,783**
Short Leasehold	**19**
	784,862
Valuers 'material uncertainty', in valuation. The disclosure relates to the materiality in the valuation report not that of the underlying account.	**0**

The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards. LHB s are required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

11.1 Property, plant and equipment

2022-23

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost at 31 March bf	78,456	691,679	3,030	23,203	130,298	546	39,785	4,184	971,181
NHS Wales Transfers	0	0	0	0	0	0	0	0	0
Prepayments	0	0	0	0	0	0	0	0	0
Transfer of Finance Leases to ROU Asset Note	(32)	(392)	0	0	0	0	(517)	0	(941)
Cost or valuation at 1 April 2022	78,424	691,287	3,030	23,203	130,298	546	39,268	4,184	970,240
Indexation	(2,002)	16,637	22	0	0	0	0	0	14,657
Additions									
- purchased	0	4,259	53	22,262	4,961	0	4,937	112	36,584
- donated	0	0	0	0	109	0	63	38	210
- government granted	0	44	0	0	18	0	0	0	62
Transfer from/into other NHS bodies	0	0	0	0	1,106	0	0	0	1,106
Reclassifications	0	6,811	0	(8,529)	(56)	0	46	10	(1,718)
Revaluations	3,694	(26,767)	(715)	0	0	0	0	0	(23,788)
Reversal of impairments	0	8,529	(153)	0	0	0	0	0	8,376
Impairments	(2,608)	(4,604)	0	0	0	0	0	0	(7,212)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(18,246)	0	(1,004)	(182)	(19,432)
At 31 March 2023	77,508	696,196	2,237	36,936	118,190	546	43,310	4,162	979,085
Depreciation at 31 March bf	0	74,177	415	0	66,042	470	18,529	1,069	**160,702**
NHS Wales Transfers	0	0	0	0	0	0	(13)	0	**(13)**
Transfer of Finance Leases to ROU Asset Note	0	(108)	0	0	0	0	(13)	0	**(121)**
Depreciation at 1 April 2022	0	74,069	415	0	66,042	470	18,516	1,069	160,581
Indexation	0	53	0	0	0	0	0	0	53
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	(10)	0	7	3	0
Revaluations	0	(56,103)	(246)	0	0	0	0	0	(56,349)
Reversal of impairments	0	(17,935)	(168)	0	0	0	0	0	(18,103)
Impairments	0	(203)	0	0	0	0	0	0	(203)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(18,185)	0	(1,004)	(182)	(19,371)
Provided during the year	0	22,241	293	0	13,152	32	6,805	413	42,936
At 31 March 2023	0	22,122	294	0	60,999	502	24,324	1,303	109,544
Net book value at 1 April 2022	78,424	617,218	2,615	23,203	64,256	76	20,752	3,115	809,659
Net book value at 31 March 2023	77,508	674,074	1,943	36,936	57,191	44	18,986	2,859	869,541
Net book value at 31 March 2023 comprises :									
Purchased	74,353	672,131	1,943	36,936	56,328	44	18,905	2,809	863,449
Donated	3,155	1,746	0	0	608	0	81	50	5,640
Government Granted	0	197	0	0	255	0	0	0	452
At 31 March 2023	77,508	674,074	1,943	36,936	57,191	44	18,986	2,859	869,541
Asset financing :									
Owned	77,508	668,777	1,943	36,936	57,049	44	18,986	2,859	864,102
On-SoFP PFI contracts	0	5,297	0	0	142	0	0	0	5,439
PFI residual interests	0	0	0	0	0	0	0	0	0
At 31 March 2023	77,508	674,074	1,943	36,936	57,191	44	18,986	2,859	869,541

The net book value of land, buildings and dwellings at 31 March 2023 comprises :

	£000
Freehold	748,040
Long Leasehold	5,410
Short Leasehold	75
	753,525

Valuers ‘material uncertainty', in valuation. The disclosure relates to the materiality in the valuation report not that of the underlying account. 0

The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards. LHB s are required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

11. Property, plant and equipment (continued)

Disclosures:

i) Donated Assets

Assets totalling £136k were purchased via Charitable funds donations during the year.

ii) Valuations

The LHBs land and Buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards.

The LHB is required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in operation.

In 2023-24, indexation has been applied to land and buildings based on indices received from the Valuation Office Agency and as agreed in the Technical Update Note 002 issued by Welsh Government on 27th October 2023. No indexation has been applied to equipment.

In addition, in 2023-24 there have been separate revaluations for six assets under construction coming into use. These include Tredegar Health and Well-being Centre, the centralised Breast Unit at Ysbyty Ystrad Fawr, the new endoscopy unit and lift upgrades at the Royal Gwent Hospital and the Staff well-being centre at Grange House in Llanfrechfa. An impairment of £3.199m is included as a result of the discovery of reinforced autoclaved aerated concrete (RAAC) in some parts of Nevill Hall Hospital.

iii) Asset Lives

Depreciated as follows:
- Land is not depreciated.
- Buildings as determined by the Valuation Office Agency.
- Equipment 5-15 years.

iv) Compensation

There has been no compensation received from third parties for assets impaired, lost or given up, that is included in the income statement.

v) Write Downs

There have not been write downs.

vi) The LHB does not hold any property where the value is materially different from its open market value.

vii) Assets Held for Sale or sold in the period.

There are no assets held for sale or sold in the period.

IFRS 13 Fair value measurement

There are no assets requiring Fair Value measurement under IFRS 13.

11. Property, plant and equipment

11.2 Non-current assets held for sale

	Land	Buildings, including dwelling	Other property, plant and equipment	Intangible assets	Other assets	Total
	£000	£000	£000	£000	£000	£000
Balance brought forward 1 April 2023	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	**0**
Revaluation	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	**0**
Add reversal of impairment of assets held for sale	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	**0**
Balance carried forward 31 March 2024	0	0	0	0	0	**0**
Balance brought forward 1 April 2022	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	**0**
Revaluation	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	**0**
Add reversal of impairment of assets held for sale	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	**0**
Balance carried forward 31 March 2023	0	0	0	0	0	**0**

11.3 Right of Use Assets

The organisation's right of use asset leases are disclosed across the relevant headings below. Most are individually insignificant, however, five are significant in their own right:
- Blaenavon Primary Care Resource Centre (LHB lease) held under Land & Buildings NBV at 31 March 2024 £1,341k
- Rhymney Integrated H&SC Resource Centre (LHB lease) held under Land & Buildings NBV at 31 March 2024 £2,317k
- Ty Gwent held under Land & Buildings NBV at 31 March 2024 £1,213k
- Biochemistry Managed Service Contract held under Plant & Machinery NBV at 31 March 2024 £2,441k
- NHH Energy scheme (previously classified as an off balance sheet PFI scheme) held under Plant & Machinery NBV at 31 March 2024 £2,180k

2023-24	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 31 March	813	16,854	0	0	8,473	559	1,660	0	**28,359**
Lease prepayments in relation to RoU Assets	0	0	0	0	0	0	0	0	**0**
Transfer of Finance Leases from PPE Note	0	0	0	0	0	0	0	0	**0**
Operating Leases Transitioning	0	0	0	0	0	0	0	0	**0**
Cost or valuation at 1 April	**813**	**16,854**	**0**	**0**	**8,473**	**559**	**1,660**	**0**	**28,359**
Additions	0	1,768	0	0	585	533	385	0	**3,271**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	-6,442	0	0	0	-232	0	0	**-6,674**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Revaluations	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
De-recognition	0	0	0	0	0	0	0	0	**0**
At 31 March	**813**	**12,180**	**0**	**0**	**9,058**	**860**	**2,045**	**0**	**24,956**
Depreciation at 31 March	98	2,118	0	0	1,519	269	488	0	**4,492**
Transfer of Finance Leases from PPE Note	0	0	0	0	0	0	0	0	**0**
Operating Leases Transitioning	0	0	0	0	0	0	0	0	**0**
Depreciation at 1 April	**98**	**2,118**	**0**	**0**	**1,519**	**269**	**488**	**0**	**4,492**
Recognition	0	0	0	0	0	0	0	0	**0**
Transfers from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	-1,169	0	0	0	-211	0	0	**-1,380**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Revaluations	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
De-recognition	0	0	0	0	0	0	0	0	**0**
Provided during the year	98	2,019	0	0	1,619	281	457	0	**4,474**
At 31 March	**196**	**2,968**	**0**	**0**	**3,138**	**339**	**945**	**0**	**7,586**
Net book value at 1 April	**715**	**14,736**	**0**	**0**	**6,954**	**290**	**1,172**	**0**	**23,867**
Net book value at 31 March	**617**	**9,212**	**0**	**0**	**5,920**	**521**	**1,100**	**0**	**17,370**

RoU Asset Total Value Split by Lessor Lessor	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
NHS Wales Peppercorn Leases	0	0	0	0	0	0	0	0	**0**
NHS Wales Market Value Leases	0	0	0	0	0	0	0	0	**0**
Other Public Sector Peppercorn Leases	606	296	0	0	0	0	0	0	**902**
Other Public Sector Market Value Leases	11	1,153	0	0	0	0	0	0	**1,164**
Private Sector Peppercorn Leases	0	0	0	0	0	0	0	0	**0**
Private Sector Market Value Leases	0	7,763	0	0	5,920	521	1,100	0	**15,304**
Total	**617**	**9,212**	**0**	**0**	**5,920**	**521**	**1,100**	**0**	**17,370**

11.3 Right of Use Assets

The organisation's right of use asset leases are disclosed across the relevant headings below. Most are individually insignificant, however, six are significant in their own right:
- Blaenavon Primary Care Resource Centre (LHB lease) held under Land & Buildings NBV at 31 March 2023 £1,468k
- Brynmawr Medical Centre held under Land & Buildings NBV at 31 March 2023 £2,839k
- Rhymney Integrated H&SC Resource Centre (LHB lease) held under Land & Buildings NBV at 31 March 2023 £2,732k
- Blaenavon Primary Care Resource Centre (managed GP practice lease) held under Land & Buildings NBV at 31 March 2023 £1,242k
- Biochemistry Managed Service Contract held under Plant & Machinery NBV at 31 March 2023 £2,709k

2022-23	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 31 March	0	0	0	0	0	0	0	0	**0**
Lease prepayments in relation to RoU Assets	0	266	0	0	157	18	0	0	**441**
Transfer of Finance Leases from PPE Note	0	424	0	0	0	0	517	0	**941**
Operating Leases Transitioning	813	15,071	0	0	6,853	342	1,143	0	**24,222**
Cost or valuation at 1 April	**813**	**15,761**	**0**	**0**	**7,010**	**360**	**1,660**	**0**	**25,604**
Additions	0	1,471	0	0	1,463	199	0	0	**3,133**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Revaluations	0	-91	0	0	0	0	0	0	**-91**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
De-recognition	0	-287	0	0	0	0	0	0	**-287**
At 31 March	**813**	**16,854**	**0**	**0**	**8,473**	**559**	**1,660**	**0**	**28,359**
Depreciation at 31 March	0	0	0	0	0	0	0	0	**0**
Transfer of Finance Leases from PPE Note	0	108	0	0	0	0	13	0	**121**
Operating Leases Transitioning	0	0	0	0	0	0	0	0	**0**
Depreciation at 1 April	**0**	**108**	**0**	**0**	**0**	**0**	**13**	**0**	**121**
Recognition	0	0	0	0	0	0	0	0	**0**
Transfers from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Revaluations	0	-108	0	0	0	0	0	0	**-108**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
De-recognition	0	0	0	0	0	0	0	0	**0**
Provided during the year	98	2,118	0	0	1,519	269	475	0	**4,479**
At 31 March	**98**	**2,118**	**0**	**0**	**1,519**	**269**	**488**	**0**	**4,492**
Net book value at 1 April	**813**	**15,653**	**0**	**0**	**7,010**	**360**	**1,647**	**0**	**25,483**
Net book value at 31 March	**715**	**14,736**	**0**	**0**	**6,954**	**290**	**1,172**	**0**	**23,867**

RoU Asset Total Value Split by Lessor Lessor	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
NHS Wales Peppercorn Leases	0	0	0	0	0	0	0	0	**0**
NHS Wales Market Value Leases	0	0	0	0	0	0	0	0	**0**
Other Public Sector Peppercorn Leases	704	314	0	0	0	0	0	0	**1,018**
Other Public Sector Market Value Leases	11	1,875	0	0	0	0	0	0	**1,886**
Private Sector Peppercorn Leases	0	0	0	0	0	0	0	0	**0**
Private Sector Market Value Leases	0	12,547	0	0	6,954	290	1,172	0	**20,963**
Total	**715**	**14,736**	**0**	**0**	**6,954**	**290**	**1,172**	**0**	**23,867**

11.3 Right of Use Assets continued

Quantitative disclosures

Maturity analysis Contractual undiscounted cash flows relating to lease liabilities	2023-24 LAND £000	2023-24 BUILDINGS £000	2023-24 OTHER £000	2023-24 TOTAL £000	2022-23 £000
Less than 1 year	0	1,531	2,179	3,710	4,235
2-5 years	2	3,641	3,907	7,550	10,489
> 5 years	11	4,668	1,478	6,157	8,948
Total	**13**	**9,840**	**7,564**	**17,417**	**23,672**

Lease Liabilities (net of irrecoverable VAT)	2023-24	2022-23
Current	3,445	4,008
Non-Current	12,892	18,464
Total	**16,337**	**22,472**

Amounts Recognised in Statement of Comprehensive Net Expenditure	2023-24	2022-23
Depreciation	4,474	4,479
Impairment	0	0
Variable lease payments not included in lease liabilities - Interest expense	274	232
Sub-leasing income	-2	-2
Expense related to short-term leases	713	552
Expense related to low-value asset leases (excluding short-term leases)	936	858

Amounts Recognised in Statement of Cashflows (net of irrecoverable VAT)		
Interest expense	-274	-232
Repayments of principal on leases	-4,099	-4,577
Total	**-4,373**	**-4,809**

12. Intangible non-current assets
2023-24

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure- internally generated	Assets under Construction	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2023	3,547	0	7,772	0	0	0	11,319
Revaluation	0	0	0	0	0	0	0
Reclassifications	35	0	0	0	0	548	583
Reversal of impairments	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	(438)	(438)
Additions- purchased	50	0	716	0	0	953	1,719
Additions- internally generated	0	0	0	0	0	0	0
Additions- donated	0	0	0	0	0	0	0
Additions- government granted	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0
Transfers	0	0	0	0	0	0	0
Disposals	(101)	0	(5,564)	0	0	0	(5,665)
Gross cost at 31 March 2024	3,531	0	2,924	0	0	1,063	7,518
Amortisation at 1 April 2023	1,129	0	5,099	0	0	0	6,228
Revaluation	0	0	(114)	0	0	0	(114)
Reclassifications	35	0	0	0	0	0	35
Reversal of impairments	0	0	0	0	0	0	0
Impairment	0	0	0	0	0	0	0
Provided during the year	737	0	1,612	0	0	0	2,349
Reclassified as held for sale	0	0	0	0	0	0	0
Transfers	0	0	0	0	0	0	0
Disposals	(101)	0	(5,564)	0	0	0	(5,665)
Amortisation at 31 March 2024	1,800	0	1,033	0	0	0	2,833
Net book value at 1 April 2023	2,418	0	2,673	0	0	0	5,091
Net book value at 31 March 2024	1,731	0	1,891	0	0	1,063	4,685
NBV at 31 March 2024							
Purchased	1,731	0	1,891	0	0	1,063	4,685
Donated	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0
Internally generated	0	0	0	0	0	0	0
Total at 31 March 2024	1,731	0	1,891	0	0	1,063	4,685

12. Intangible non-current assets
2022-23

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure- internally generated	Assets under Construction	**Total**
	£000	£000	£000	£000	£000	£000	**£000**
Cost or valuation at 1 April 2022	**1,838**	**0**	**7,535**	**0**	**0**	**0**	**9,373**
Revaluation	0	0	0	0	0	0	**0**
Reclassifications	1,718	0	0	0	0	0	**1,718**
Reversal of impairments	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	**0**
Additions- purchased	66	0	955	0	0	0	**1,021**
Additions- internally generated	0	0	0	0	0	0	**0**
Additions- donated	0	0	0	0	0	0	**0**
Additions- government granted	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	**0**
Transfers	0	0	0	0	0	0	**0**
Disposals	(75)	0	(718)	0	0	0	**(793)**
Gross cost at 31 March 2023	**3,547**	**0**	**7,772**	**0**	**0**	**0**	**11,319**
Amortisation at 31 March bf	**714**	**0**	**3,448**	**0**	**0**	**0**	**4,162**
NHS Wales Transfers	0	0	0	0	0	0	**0**
Transfer of Finance Leases to ROU Asset Note	0	0	0	0	0	0	**0**
Amortisation at 1 April 2022	**714**	**0**	**3,448**	**0**	**0**	**0**	**4,162**
Revaluation	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	**0**
Impairment	0	0	0	0	0	0	**0**
Provided during the year	490	0	2,369	0	0	0	**2,859**
Reclassified as held for sale	0	0	0	0	0	0	**0**
Transfers	0	0	0	0	0	0	**0**
Disposals	(75)	0	(718)	0	0	0	**(793)**
Amortisation at 31 March 2023	**1,129**	**0**	**5,099**	**0**	**0**	**0**	**6,228**
Net book value at 1 April 2022	**1,124**	**0**	**4,087**	**0**	**0**	**0**	**5,211**
Net book value at 31 March 2023	**2,418**	**0**	**2,673**	**0**	**0**	**0**	**5,091**
NBV at 31 March 2023							
Purchased	2,418	0	2,673	0	0	0	**5,091**
Donated	0	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	0	**0**
Internally generated	0	0	0	0	0	0	**0**
Total at 31 March 2023	**2,418**	**0**	**2,673**	**0**	**0**	**0**	**5,091**

Additional Disclosures re Intangible Assets

Disclosures:

i) Donated Assets

Aneurin Bevan University LHB has not received any donated intangible assets during the year.

ii) Recognition

Intangible assets acquired separately are initially recognised at fair value. The amount recognised for internally-generated intangible assets is the sum of the expenditure incurred to date when the criteria for recognising internally generated assets has been met (see accounting policy 1.7 for criteria).

iii) Asset Lives

The useful economic life of Intangible non-current assets are assigned on an individual asset basis. Software is generally assigned a 5 year UEL and the UEL of internally generated software is based on the professional judgement of LHB professionals and Finance staff.

iv) Additions during the period

Intangible assets acquired during the period amounted to £1.719m; this was primarily on software licence renewals and new purchases.

v) Disposals during the period

Fully amortised software and licences with a GBV of £5.665m were disposed of as no longer in use, during the year.

13 . Impairments

	2023-24 Property, plant & equipment £000	**2023-24 Right of Use Assets £000**	**2023-24 Intangible assets £000**	2022-23 Property, plant & equipment £000	2022-23 Right of Use Assets £000	2022-23 Intangible assets £000
Impairments arising from :						
Loss or damage from normal operations	**0**	**0**	**0**	0	0	0
Abandonment in the course of construction	**438**	**0**	**0**	0	0	0
Over specification of assets (Gold Plating)	**0**	**0**	**0**	0	0	0
Loss as a result of a catastrophe	**0**	**0**	**0**	0	0	0
Unforeseen obsolescence	**0**	**0**	**0**	0	0	0
Changes in market price	**0**	**0**	**0**	0	0	0
Others (specify)	**31,284**	**0**	**0**	10,557	0	0
Reversal of Impairments	**(19,552)**	**0**	**0**	(26,479)	0	0
Total of all impairments	**12,170**	**0**	**0**	(15,922)	0	0
Analysis of impairments charged to reserves in year :						
Charged to the Statement of Comprehensive Net Expenditure	**10,170**	**0**	**0**	(19,470)	0	0
Impairments as a result of a loss of economic value or service potential Charged to Revaluation Reserve	**2,000**	**0**	**0**	3,548	0	0
Total	**12,170**	**0**	**0**	(15,922)	0	0

2023-24	Impairment amount £000	Reason for impairment £000	Nature of Asset £000	Valuation basis £000	Charge to SoCNE £000	Charge to reserve £000
Indexation - Land	2,397	Indexation loss	Operational	Existing Use	397	2,000
Tredegar HWBC (Bevan Health Centre	13,403	Assets Valued on Coming Into Use	Operational	Fair Value	13,403	0
Endoscopy Redevelopment, RGH	5,978	Assets Valued on Coming Into Use	Operational	Fair Value	5,978	0
YYF Unified Breast Unit	5,796	Assets Valued on Coming Into Use	Operational	Fair Value	5,796	0
RAAC at NHH	3,199	Economic Loss / Assets Valued on Coming Into Use	Operational	Fair Value	3,199	0
Grange House Wellbeing Centre, LGH	511	Assets Valued on Coming Into Use	Operational	Fair Value	511	0
WCCIS Phase 2 - abandonment of AU	438	Abandoned development	Intangible AUC	Fair Value	438	0
Total Impairment	31722				29722	2000
Reversal of Impairments						
Grange University Hospital	(16,154)	Indexation - reversal of impairment in previous years	Operational	Indexation	(16,154)	
Ysbyty Aneurin Bevan	(2,318)		Operational	Indexation	(2,318)	
Neville Hall	(536)		Operational	Indexation	(536)	
Royal Gwent	(200)		Operational	Indexation	(200)	
St Cadocs	(153)		Operational	Indexation	(153)	
Llanfrechfa Grange	(135)		Operational	Indexation	(135)	
Various Community Sites	(56)		Operational	Indexation	(56)	
Total Reversal of Impairments	-19552				-19552	0
Net credit to SoCNE	12170				10170	2000

14.1 Inventories

	31 March 2024	31 March 2023
	£000	£000
Drugs	**3,095**	2,819
Consumables	**6,482**	6,471
Energy	**267**	286
Work in progress	**0**	0
Other	**0**	0
Total	**9,844**	9,576
Of which held at realisable value	**0**	0

14.2 Inventories recognised in expenses

	31 March 2024	31 March 2023
	£000	£000
Inventories recognised as an expense in the period	**0**	0
Write-down of inventories (including losses)	**0**	0
Reversal of write-downs that reduced the expense	**0**	0
Total	**0**	**0**

15. Trade and other Receivables

Current	**31 March 2024 £000**	31 March 2023 £000
Welsh Government	**2,246**	1,517
WHSSC / EASC	**2,911**	1,019
Welsh Health Boards	**3,971**	3,175
Welsh NHS Trusts	**5,901**	4,309
Welsh Special Health Authorities	**1,044**	1,010
Non - Welsh Trusts	**24**	66
Other NHS	**267**	213
2019-20 Scheme Pays - Welsh Government Reimbursement	**604**	141
Welsh Risk Pool Claim reimbursement		
NHS Wales Secondary Health Sector	**93,727**	109,290
NHS Wales Primary Sector FLS Reimbursement	**920**	111
NHS Wales Redress	**502**	587
Other	**791**	0
Local Authorities	**5,468**	9,756
Capital receivables - Tangible	**0**	0
Capital receivables - Intangible	**0**	0
Other receivables	**12,766**	16,714
Provision for irrecoverable debts	**(1,942)**	(1,763)
Pension Prepayments NHS Pensions	**0**	0
Pension Prepayments NEST	**0**	0
Other prepayments	**7,373**	6,017
Other accrued income	**0**	0
Sub total	**136,573**	152,162
Non-current		
Welsh Government	**0**	0
WHSSC / EASC	**0**	0
Welsh Health Boards	**0**	0
Welsh NHS Trusts	**0**	0
Welsh Special Health Authorities	**0**	0
Non - Welsh Trusts	**0**	0
Other NHS	**0**	0
2019-20 Scheme Pays - Welsh Government Reimbursement	**0**	0
Welsh Risk Pool Claim reimbursement;		
NHS Wales Secondary Health Sector	**142,085**	76,333
NHS Wales Primary Sector FLS Reimbursement	**0**	2
NHS Wales Redress	**0**	0
Other	**744**	0
Local Authorities	**0**	0
Capital receivables - Tangible	**0**	0
Capital receivables - Intangible	**0**	0
Other receivables	**1,237**	1,131
Provision for irrecoverable debts	**0**	0
Pension Prepayments NHS Pensions	**0**	0
Pension Prepayments NEST	**0**	0
Other prepayments	**0**	0
Other accrued income	**0**	0
Sub total	**144,066**	77,466
Total	**280,639**	229,628

15. Trade and other Receivables (continued)

Receivables past their due date but not impaired

	31 March 2024 £000	31 March 2023 £000
By up to three months	**1,922**	2,415
By three to six months	**383**	360
By more than six months	**1,570**	1,331
	3,875	4,106

Expected Credit Losses (ECL) / Provision for impairment of receivables

Balance at 1 April	**(1,763)**	(1,870)
Transfer to other NHS Wales body	**0**	0
Amount written off during the year	**20**	0
Amount recovered during the year	**0**	3
(Increase) / decrease in receivables impaired	**(176)**	119
Bad debts recovered during year	**(22)**	(15)
Balance at 31 March	**(1,942)**	(1,763)

In determining whether a debt is impaired, consideration is given to the age of the debt and the results of actions taken to recover the debt, including reference to credit agencies.

Receivables VAT

Trade receivables	**2,091**	1,899
Other	**195**	92
Total	**2,286**	1,991

16. Other Financial Assets

	Current		Non-current	
	31 March 2024	31 March 2023	**31 March 2024**	31 March 2023
	£000	£000	**£000**	£000
Financial assets				
Shares and equity type investments				
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCNE	**0**	0	**0**	0
Available for sale at FV	**0**	0	**0**	0
Deposits	**0**	0	**0**	0
Loans	**35**	34	**452**	487
Derivatives	**0**	0	**0**	0
Other (Specify)				
Right of Use Asset Finance Sublease	**24**	24	**215**	239
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCNE	**0**	0	**0**	0
Available for sale at FV	**0**	0	**0**	0
Total	**59**	**58**	**667**	**726**

RoU Sub-leasing income Recognised in Statement of Comprehensive Net Expenditure	**2023-24**	**2022-23**
RoU Sub-leasing income	**-2**	-2

17. Cash and cash equivalents

	2023-24	2022-23
	£000	£000
Balance at 1 April	**4,704**	1,720
Net change in cash and cash equivalent balances	**(559)**	2,984
Balance at 31 March	**4,145**	4,704
Made up of:		
Cash held at GBS	**4,122**	4,681
Commercial banks	**0**	0
Cash in hand	**23**	23
Cash and cash equivalents as in Statement of Financial Position	**4,145**	4,704
Bank overdraft - GBS	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in Statement of Cash Flows	**4,145**	4,704

In response to the IAS 7 requirement for additional disclosure, the changes in liabilities arising for financing activities are;

Lease Liabilities (ROUA) -£6.135m
Lease Liabilities (short-term and low value leases) £0.465m
PFI liabilities: £0.478m

The movement relates to cash, no comparative information is required by IAS 7 in 2023-24.

18. Trade and other payables

Current	**31 March 2024**	31 March 2023
	£000	£000
Welsh Government	**22**	44
WHSSC / EASC	**4,681**	3,125
Welsh Health Boards	**5,964**	3,461
Welsh NHS Trusts	**5,416**	6,088
Welsh Special Health Authorities	**39**	80
Other NHS	**7,477**	4,559
Taxation and social security payable / refunds	**16,072**	17,761
Refunds of taxation by HMRC	**0**	0
VAT payable to HMRC	**0**	0
Other taxes payable to HMRC	**0**	0
NI contributions payable to HMRC	**0**	0
Non-NHS payables - Revenue	**56,646**	58,923
Local Authorities	**19,638**	27,191
Capital payables- Tangible	**6,493**	7,189
Capital payables- Intangible	**147**	206
Overdraft	**0**	0
Rentals due under operating leases	**0**	0
RoU Lease Liability	**3,445**	4,008
Obligations under finance leases, HP contracts	**0**	0
Imputed finance lease element of on SoFP PFI contracts	**638**	1,036
Impact of IFRS 16 on SoFP PFI contracts	**108**	0
Pensions: staff	**10,718**	9,797
Non NHS Accruals	**74,734**	88,638
Deferred Income:		
Deferred Income brought forward	**0**	0
Deferred Income Additions	**0**	0
Transfer to / from current/non current deferred income	**0**	0
Released to SoCNE	**0**	0
Other creditors	**0**	0
PFI assets –deferred credits	**0**	0
Payments on account	**(10,088)**	(9,982)
Sub Total	**202,150**	222,124
Non-current		
Welsh Government	**0**	0
WHSSC / EASC	**0**	0
Welsh Health Boards	**0**	0
Welsh NHS Trusts	**0**	0
Welsh Special Health Authorities	**0**	0
Other NHS	**0**	0
Taxation and social security payable / refunds	**0**	0
Refunds of taxation by HMRC	**0**	0
VAT payable to HMRC	**0**	0
Other taxes payable to HMRC	**0**	0
NI contributions payable to HMRC	**0**	0
Non-NHS payables - Revenue	**0**	0
Local Authorities	**0**	0
Capital payables- Tangible	**0**	0
Capital payables- Intangible	**0**	0
Overdraft	**0**	0
Rentals due under operating leases	**0**	0
RoU Lease Liability	**12,892**	18,464
Obligations under finance leases, HP contracts		0
Imputed finance lease element of on SoFP PFI contracts	**1,590**	2,228
Impact of IFRS 16 on SoFP PFI contracts	**1,406**	0
Pensions: staff	**0**	0
Non NHS Accruals	**0**	0
Deferred Income :		
Deferred Income brought forward	**0**	0
Deferred Income Additions	**0**	0
Transfer to / from current/non current deferred income	**0**	0
Released to SoCNE	**0**	0
Other creditors	**0**	0
PFI assets –deferred credits	**0**	0
Payments on account	**0**	0
Sub Total	**15,888**	20,692
Total	**218,038**	242,816

It is intended to pay all invoices within the 30 day period directed by the Welsh Government.

The Capital Payables - Tangible figure includes balances that have been agreed with Welsh NHS Trusts, as part of the Agreement of Balances process, totalling £53k.

In 2023/24, the PFI Contract liabilities have been adjusted due to the IFRS16 requirement to reflect the impact of RPI increases within the scheme obligations. The liability is now split out over 4 lines.

18. Trade and other payables (continued).

Amounts falling due more than one year are expected to be settled as follows:	**31 March 2024 £000**	31 March 2023 £000
Between one and two years	**3,182**	4,352
Between two and five years	**4,810**	6,585
In five years or more	**7,896**	9,755
Sub-total	**15,888**	20,692

19. Other financial liabilities

	Current		**Non-current**	
Financial liabilities	**31 March 2024 £000**	31 March 2023 £000	**31 March 2024 £000**	31 March 2023 £000
Financial Guarantees:				
At amortised cost	**0**	0	**0**	0
At fair value through SoCNE	**0**	0	**0**	0
Derivatives at fair value through SoCNE	**0**	0	**0**	0
Other:				
At amortised cost	**0**	0	**0**	0
At fair value through SoCNE	**0**	0	**0**	0
Total	**0**	0	**0**	0

20. Provisions

	At 1 April 2023	Structured settlement cases transferred to Risk Pool	Transfer of provisions to creditors	Transfer between current and non-current	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2024
Current	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical negligence:-									
Secondary care	80,878	(10,810)	4,456	652	33,576	(25,049)	(19,563)	0	64,140
Primary care	79	0	0	0	820	(105)	(3)	0	791
Redress Secondary care	331	0	(1)	0	363	(288)	(142)	0	263
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	479	0	0	0	436	(631)	(247)	0	37
All other losses and special payments	0	0	0	0	821	(821)	0	0	0
Defence legal fees and other administration	2,306	0	0	181	1,402	(1,314)	(621)		1,954
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	385			41	401	(401)	(103)	74	397
2019-20 Scheme Pays - Reimbursement	6			0	1	0	0	0	7
Restructuring	0			0	0	0	0	0	0
RoU Asset Dilapidations CAME	0			0	0	0	0	0	0
Other Capital Provisions	449			0	1,278	0	0	0	1,727
Other	2,367		0	0	1,429	(3)	(1,282)		2,511
Total	87,280	(10,810)	4,455	874	40,527	(28,612)	(21,961)	74	71,827
Non Current									
Clinical negligence:-									
Secondary care	74,527	0	0	(652)	76,834	(948)	(7,734)	0	142,027
Primary care	0	0	0	0	0	0	0	0	0
Redress Secondary care	0	0	0	0	0	0	0	0	0
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	2,770	0	0	0	545	(356)	0	68	3,027
All other losses and special payments	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	775	0	0	(181)	587	(104)	(60)		1,017
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	2,627			(41)	0	0	0	0	2,586
2019-20 Scheme Pays - Reimbursement	136			0	461	0	0	0	597
Restructuring	0			0	0	0	0	0	0
RoU Asset Dilapidations CAME	0			0	0	0	0	0	0
Other Capital Provisions	0			0	0	0	0	0	0
Other	351		0	0	272	(140)	(90)		393
Total	81,186	0	0	(874)	78,699	(1,548)	(7,884)	68	149,647
TOTAL									
Clinical negligence:-									
Secondary care	155,405	(10,810)	4,456	0	110,410	(25,997)	(27,297)	0	206,167
Primary care	79	0	0	0	820	(105)	(3)	0	791
Redress Secondary care	331	0	(1)	0	363	(288)	(142)	0	263
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	3,249	0	0	0	981	(987)	(247)	68	3,064
All other losses and special payments	0	0	0	0	821	(821)	0	0	0
Defence legal fees and other administration	3,081	0	0	0	1,989	(1,418)	(681)		2,971
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	3,012			0	401	(401)	(103)	74	2,983
2019-20 Scheme Pays - Reimbursement	142			0	462	0	0	0	604
Restructuring	0			0	0	0	0	0	0
RoU Asset Dilapidations CAME	0			0	0	0	0	0	0
Other Capital Provisions	449			0	1,278	0	0	0	1,727
Other	2,718		0	0	1,701	(143)	(1,372)		2,904
Total	168,466	(10,810)	4,455	0	119,226	(30,160)	(29,845)	142	221,474

Expected timing of cash flows:

	In year to 31 March 2025	Between 1 April 2025 31 March 2029	Thereafter	Total
				£000
Clinical negligence:-				
Secondary care	64,140	142,027	0	206,167
Primary care	791	0	0	791
Redress Secondary care	263	0	0	263
Redress Primary care	0	0	0	0
Personal injury	37	3,026	0	3,063
All other losses and special payments	0	0	0	0
Defence legal fees and other administration	1,954	1,018	0	2,972
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	397	2,586	0	2,983
2019-20 Scheme Pays - Reimbursement	7	35	562	604
Restructuring	0	0	0	0
RoU Asset Dilapidations CAME	0	0	0	0
Other Capital Provisions	1,727	0	0	1,727
Other	2,511	393	0	2,904
Total	71,827	149,085	562	221,474

The expected timing of cash flows are based on best available information; but they could change on the basis of individual case changes. The claims outstanding with the Welsh Risk Pool are based on best estimates of settlement of claims provided by the Health Board's legal advisors. The Health Board estimates that in 2024/25 it will receive £65,272K and in 2025/26 and beyond £142,829K from the Welsh Risk Pool in respect of clinical negligence and personal injury payments.

Other provisions include: Continuing Healthcare Independent Review Panel (IRP) & Ombudsman claims £393K. The estimation method used to calculate the provision for 2023/24 is consistent with the methodology used in 2022/23. In the continuing absence of detailed assessment information the Health Board has used a mixture of actual assessments and the application of an expected success factor and average weekly costs to determine whether an individual claimant provision would be established.
Other provisions include an amount for Ancillary Staff Banked Annual Leave Payments, potential VAT payment to HMRC and Capital provision.
The total Health Board provision also includes an amount of £270K which relates to 52 Redress cases where offers have been made to the families but not yet accepted or breach and causation have been proven.

20. Provisions (continued)

	At 1 April 2022	Structured settlement cases transferred to Risk Pool	Transfer of provisions to creditors	Transfer between current and non-current	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2023
Current	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Clinical negligence:-									
Secondary care	56,805	(16,033)	(8,975)	52,699	42,660	(11,816)	(34,462)	0	**80,878**
Primary care	41	0	0	0	40	(2)	0	0	**79**
Redress Secondary care	126	0	(117)	0	516	(148)	(46)	0	**331**
Redress Primary care	0	0	0	0	0	0	0	0	**0**
Personal injury	599	0	0	0	786	(598)	(308)	0	**479**
All other losses and special payments	0	0	0	0	34	(34)	0	0	**0**
Defence legal fees and other administration	2,239	0	0	327	1,953	(1,334)	(879)		**2,306**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	395			684	50	(392)	(415)	63	**385**
2019-20 Scheme Pays - Reimbursement	11			0	0	(5)	0	0	**6**
Restructuring	0			0	0	0	0	0	**0**
RoU Asset Dilapidations CAME	0			0	0	0	0	0	**0**
Other Capital Provisions	0			0	449	0	0	0	**449**
Other	3,067		0	0	(13)	(5)	(682)		**2,367**
Total	**63,283**	**(16,033)**	**(9,092)**	**53,710**	**46,475**	**(14,334)**	**(36,792)**	**63**	**87,280**
Non Current									
Clinical negligence:-									
Secondary care	123,659	0	0	(52,699)	5,380	(696)	(1,117)	0	**74,527**
Primary care	0	0	0	0	0	0	0	0	**0**
Redress Secondary care	0	0	0	0	0	0	0	0	**0**
Redress Primary care	0	0	0	0	0	0	0	0	**0**
Personal injury	3,262	0	0	0	36	(262)	(321)	55	**2,770**
All other losses and special payments	0	0	0	0	0	0	0	0	**0**
Defence legal fees and other administration	1,042	0	0	(327)	144	(50)	(34)		**775**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	3,311			(684)	0	0	0	0	**2,627**
2019-20 Scheme Pays - Reimbursement	745			0	0	(3)	(606)	0	**136**
Restructuring	0			0	0	0	0	0	**0**
RoU Asset Dilapidations CAME	0			0	0	0	0	0	**0**
Other Capital Provisions	0			0	0	0	0	0	**0**
Other	405		0	0	137	(97)	(94)		**351**
Total	**132,424**	**0**	**0**	**(53,710)**	**5,697**	**(1,108)**	**(2,172)**	**55**	**81,186**
TOTAL									
Clinical negligence:-									
Secondary care	180,464	(16,033)	(8,975)	0	48,040	(12,512)	(35,579)	0	**155,405**
Primary care	41	0	0	0	40	(2)	0	0	**79**
Redress Secondary care	126	0	(117)	0	516	(148)	(46)	0	**331**
Redress Primary care	0	0	0	0	0	0	0	0	**0**
Personal injury	3,861	0	0	0	822	(860)	(629)	55	**3,249**
All other losses and special payments	0	0	0	0	34	(34)	0	0	**0**
Defence legal fees and other administration	3,281	0	0	0	2,097	(1,384)	(913)		**3,081**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	3,706			0	50	(392)	(415)	63	**3,012**
2019-20 Scheme Pays - Reimbursement	756			0	0	(8)	(606)	0	**142**
Restructuring	0			0	0	0	0	0	**0**
RoU Asset Dilapidations CAME	0			0	0	0	0	0	**0**
Other Capital Provisions	0			0	449	0	0	0	**449**
Other	3,472		0	0	124	(102)	(776)		**2,718**
Total	**195,707**	**(16,033)**	**(9,092)**	**0**	**52,172**	**(15,442)**	**(38,964)**	**118**	**168,466**

The expected timing of cash flows are based on best available information; but they could change on the basis of individual case changes. The claims outstanding with the Welsh Risk Pool are based on best estimates of settlement of claims provided by the Health Board's legal advisors. The Health Board estimates that in 2023/24 it will receive £82,013,376 and in 2024/25 and beyond £74,980,511 from the Welsh Risk Pool in respect of clinical negligence and personal injury payments.

Other provisions include: Continuing Healthcare Independent Review Panel (IRP) & Ombudsman claims £426,553. The estimation method used to calculate the provision for 2022/23 is consistent with the methodology used in 2021/22. In the continuing absence of detailed assessment information the Health Board has used a mixture of actual assessments and the application of an expected success factor and average weekly costs to determine whether an individual claimant provision would be established.
Other provisions include an amount for Ancillary Staff Banked Annual Leave Payments, potential VAT payment to HMRC and Capital provision.
The total Health Board provision also includes an amount of £340,184 which relates to 50 Redress cases where offers have been made to the families but not yet accepted or breach and causation have been proven.

Provision (Continued)

Pensions tax annual allowance – Scheme Pays arrangements 2019/20

In accordance with a Ministerial Direction issued on 18 December 2019, the Welsh Government have taken action to support circumstances where pensions tax rules are impacting upon clinical staff who want to work additional hours, and have determined that:

- clinical staff who are members of the NHS Pension Scheme and who, as a result of work undertaken in the 2019-20 tax year, face a tax charge on the growth of their NHS pension benefits, may opt to have this charge paid by the NHS Pension Scheme, with their pension reduced on retirement.

Welsh Government, on behalf of the Aneurin Bevan University Health Board, will pay the members who opt for reimbursement of their pension, a corresponding amount on retirement, ensuring that they are fully compensated for the effect of the deduction.

This scheme will be funded directly by the Welsh Government to the NHS Business Services Authority Pension Division, the administrators on behalf of the Welsh claimants.

Clinical staff have until 31 March 2022 to opt for this scheme and the ability to make changes up to 31 July 2026.

The Health Board have included a Scheme Pay provsion of £604,453 (as notified by Welsh Government) within these accounts.

21. Contingencies

21.1 Contingent liabilities

Provisions have not been made in these accounts for the following amounts :	**2023-24 £'000**	2022-23 £'000
Legal claims for alleged medical or employer negligence:-		
Secondary care	**271,446**	337,156
Primary care	**547**	1,251
Redress Secondary care	**3**	0
Redress Primary care	**0**	3
Doubtful debts	**0**	0
Equal Pay costs	**0**	0
Defence costs	**4,244**	4,625
Continuing Health Care costs	**1,483**	1,379
Other	**0**	0
Total value of disputed claims	**277,723**	344,414
Amounts (recovered) in the event of claims being successful	**(272,258)**	(339,412)
Net contingent liability	**5,465**	5,002

Other litigation claims could arise in the future due to known incidents. The expenditure which may arise from such claims cannot be determined and no provision has been made for them. The value of legal claims has decreased by £66m from the value of legal claims in 2022-23, while the number of claims has increased from 224 in 2022-23 to 236 in 2023-24.

Liability for Permanent Injury Benefit under the NHS Injury Benefit Scheme lies with the employer. Individual claims to the NHS Pensions Agency could arise due to known incidents.

Continuing Healthcare Cost uncertainties

The Health Board continues to review claims for reimbursement of retrospective care payments (IRPs). As a consequence there has been a movement in the level of provision and uncertainty including in these Accounts.

Note 20 sets out the £0.393m provision made for probable continuing care costs relating to 69 outstanding phase 3 to 8 claims received by 31st March 2024. This compares with the 2022/23 provision of £0.427m and 52 outstanding phase 1 to 8 claims.

Note 21.1 also sets out the £1.483m contingent liability for possible additional continuing care costs relating to those claims if they are all settled and in full, comparing adversely with the £1.379m reported for 2022/23.

There are still 14 new (Phase 8) claims, which have been received whereby the assessment process remains incomplete, as we are still awaiting full details to support the claims. The assessment process is highly complex and involves a multi-disciplinary teams and for those reasons can take many months. At this stage, the HB does not have enough information to make a judgement on the likely success or otherwise of these claims, however, they may result in additional costs to the HB, which cannot be quantified at this time.

The Health Board are also aware of an incident from 2019 that has been investigated by the Health and Safety Executive. The HSE have yet to make an enforcement decision and as such can not be quantified at this time.

21.2 Remote Contingent liabilities

	2023-24	2022-23
	£000	£000
Guarantees	**0**	0
Indemnities	**24,064**	33,808
Letters of Comfort	**0**	0
Total	**24,064**	**33,808**

The remote contingent liabilities cost consists of 3 medical negligence cases and 1 GP Indemnity case in 2023-24 (11 medical medical negligence cases in 2022-23). Should these cases progress the majority of the costs incurred, in excess of £25K per case attributable to the Health Board, will be recovered from the Welsh Risk Pool.

21.3 Contingent assets

	2023-24	2022-23
	£000	£000
	0	0
Total	**0**	0

22. Capital commitments

Contracted capital commitments at 31 March

The disclosure of future capital commitments not already disclosed as liabilities in the accounts.

	2023-24	2022-23
	£000	£000
Property, plant and equipment	**25,569**	54,039
Right of Use Assets	**0**	0
Intangible assets	**173**	689
Total	**25,742**	54,728

23. Losses and special payments

Losses and special payments are charged to the Statement of Comprehensive Net Expenditure in accordance with IFRS but are recorded in the losses and special payments register when payment is made. Therefore, the payments in this note are prepared on a cash basis.

Gross loss to the Exchequer

23.1 Number of cases and associated amounts paid out during the financial year

	Amounts paid out during period to 31 March 2024	
	Number	**£**
Clinical negligence	339	27,570,923
Personal injury	122	1,227,151
All other losses and special payments	162	840,374
Total	623	29,638,448

23.2 Analysis of number of cases and associated amounts paid out during the financial year

	Case Type	**In year claims in excess of £300,000**		**Cumulative amount**
		Case Number	**£**	**£**
Cases in excess of £300,000:				
	Medical Negligence	MN/107/3636	307,970	317,891
	Medical Negligence	MN/107/3228	335,100	345,200
	Medical Negligence	MN/107/3721	603,501	699,738
	Medical Negligence	MN/107/0905	2,927,075	3,348,998
	Medical Negligence	MN/107/2957	874,191	1,039,724
	Medical Negligence	MN/107/2754	4,239,790	4,685,760
	Medical Negligence	MN/107/2012	329,270	958,516
	Medical Negligence	MN/107/3477	839,436	885,840
	Medical Negligence	MN/107/3253	995,303	1,032,161
	Medical Negligence	MN/107/3309	3,407,775	3,994,620
	Medical Negligence	MN/107/2594	4,653,438	4,806,234
	Personal Injury	PI/107/3465	371,116	374,896
	Other Losses		756,007	756,007
		No of cases	**£**	**£**
Sub-total		**13**	**20,639,972**	**23,245,585**
All other cases paid in year		610	8,998,476	30,351,538
Total cases paid in year		**623**	**29,638,448**	**53,597,123**

24. Right of Use / Finance leases obligations

24.1 Obligations (as lessee)

Amounts payable under right of use asset leases:

2023-24

	LAND	BUILDINGS	OTHER	TOTAL
	31 March	31 March	31 March	31 March
	2024	2024	2024	2024
Minimum lease payments	£000	£000	£000	£000
Within one year	0	1,531	2,179	**3,710**
Between one and five years	2	3,641	3,907	**7,550**
After five years	11	4,668	1,478	**6,157**
Less finance charges allocated to future periods	-2	-762	-316	**-1,080**
Minimum lease payments	**11**	**9,078**	**7,248**	**16,337**
Included in:				
Current borrowings	0	1,402	2,043	**3,445**
Non-current borrowings	11	7,676	5,205	**12,892**
	11	9078	7248	**16337**
Present value of minimum lease payments				
Within one year	0	1,402	2,043	**3,445**
Between one and five years	1	3,250	3,755	**7,006**
After five years	10	4,426	1,450	**5,886**
Present value of minimum lease payments	**11**	**9,078**	**7,248**	**16,337**
Included in:				
Current borrowings	0	1,402	2,043	**3,445**
Non-current borrowings	11	7,676	5,205	**12,892**
	11	9078	7248	**16337**

2022-23

	LAND	BUILDINGS	OTHER	TOTAL
	31 March	31 March	31 March	31 March
	2023	2023	2023	2023
Minimum lease payments	£000	£000	£000	£000
Within one year	0	2,209	2,025	4,234
Between one and five years	1	6,076	4,412	10,489
After five years	12	7,156	1,781	8,949
Less finance charges allocated to future periods	-2	-954	-243	-1,199
Minimum lease payments	11	14,487	7,975	22,473
Included in:				
Current borrowings	0	2,053	1,955	**4,008**
Non-current borrowings	11	12,434	6,020	**18,465**
	11	14487	7975	**22473**
Present value of minimum lease payments				
Within one year	0	2,053	1,955	4,008
Between one and five years	1	5,631	4,281	9,913
After five years	10	6,803	1,739	8,552
Present value of minimum lease payments	11	14,487	7,975	22,473
Included in:				
Current borrowings	0	2,053	1,955	**4,008**
Non-current borrowings	11	12,434	6,020	**18,465**
	11	14487	7975	**22473**

24.3 Right of Use Assets / Finance lease receivables (as lessor)

The Local Health Board has no finance leases receivable as a lessor.

Amounts receivable under right of use assets / finance leases:	**2023-24**	2022-23
	31 March	31 March
	2024	2023
Gross Investment in leases	**£000**	£000
Within one year	**26**	26
Between one and five years	**106**	106
After five years	**118**	144
Less finance charges allocated to future periods	**(11)**	(13)
Minimum lease payments	**239**	263
Included in:		
Current borrowings	**24**	24
Non-current borrowings	**215**	239
	239	263
Present value of minimum lease payments		
Within one year	**24**	24
Between one and five years	**99**	98
After five years	**116**	141
Less finance charges allocated to future periods	**0**	0
Present value of minimum lease payments	**239**	263
Included in:		
Current borrowings	**24**	24
Non-current borrowings	**215**	239
	239	263

25. Private Finance Initiative contracts

25.1 PFI schemes off-Statement of Financial Position

The LHB has one PFI Scheme that was previously classified as off-statement of financial position. The scheme related to the provision of replacement heating and lighting systems within Nevill Hall hospital. The scheme commenced in 2000 for a period of 25 years. Since the introduction of IFRS 16 in 2022/23, the off-statement of Financial Position PFI has been recognised as a Right of use Asset.

Commitments under off-SoFP PFI contracts	**Off-SoFP PFI contracts 31 March 2024 £000**	Off-SoFP PFI contracts 31 March 2023 £000
Total payments due within one year	**0**	0
Total payments due between 1 and 5 years	**0**	0
Total payments due thereafter	**0**	0
Total future payments in relation to PFI contracts	**0**	0
Total estimated capital value of off-SoFP PFI contracts	**0**	0

25.2 PFI schemes on-Statement of Financial Position

Capital value of scheme included in Fixed Assets Note 11	**£000**
	626
Contract start date:	Feb-00
Contract end date:	Feb-25

Chepstow Community Hospital - a new community hospital including the provision of ancillary support services. This scheme commenced in 1998 with unitary charge payments being made for a period of 25 years from February 2000. The obligation for the scheme is £468k.

Capital value of scheme included in Fixed Assets Note 11	**£000**
	3,932
Contract start date:	Mar-04
Contract end date:	Mar-36

Monnow Vale Health and Social Care Facility - a new health and social care facility. This scheme commenced in 2006 with unitary charge payments being made for a period of 30 years from 2006. The obligation for the scheme is £3,226k. In 2023/24, the liability for the scheme was increased by £1,618k due to the IFRS16 requirement to reflect the impact of RPI increases within the scheme obligation.

	£000
Capital value of scheme included in Fixed Assets Note 11	**96**
Contract start date:	Sep-99
Contract end date:	Jun-24

Nevill Hall Hospital Day Surgery - a purpose built day unit including the provision of medical equipment for the unit. The PFI partner has responsibility for maintaining the building and replacing the equipment used with the unit. The scheme commenced in 1998 with unitary charge payments being made for a period of 25 years from 1999. The obligation for the scheme is £45k. In 2023/24, the liability for the scheme was increased by £444k due to the IFRS16 requirement to reflect the impact of RPI increases within the scheme obligation.

Total obligations for on-Statement of Financial Position PFI contracts due:

	On SoFP PFI Capital element 31 March 2024 £000	**On SoFP PFI Imputed interest 31 March 2024 £000**	**On SoFP PFI Service charges 31 March 2024 £000**
Total payments due within one year	**746**	**80**	**2,888**
Total payments due between 1 and 5 years	**985**	**338**	**2,856**
Total payments due thereafter	**2,011**	**222**	**5,080**
Total future payments in relation to PFI contracts	**3,742**	**640**	**10,824**

	On SoFP PFI Capital element 31 March 2023 £000	On SoFP PFI Imputed interest 31 March 2023 £000	On SoFP PFI Service charges 31 March 2023 £000
Total payments due within one year	1,036	166	3,235
Total payments due between 1 and 5 years	1,025	209	5,592
Total payments due thereafter	1,203	157	6,553
Total future payments in relation to PFI contracts	3,264	532	15,380

	31/03/2024 £000
Total present value of obligations for on-SoFP PFI contracts	**15,206**

25.3 Charges to expenditure	2023-24	2022-23
	£000	£000
Service charges for On Statement of Financial Position PFI contracts (excl interest costs)	2,394	2,346
Total expense for Off Statement of Financial Position PFI contracts	0	0
The total charged in the year to expenditure in respect of PFI contracts	2,394	2,346

The LHB is committed to the following annual charges

PFI scheme expiry date:	£000	£000
Not later than one year	1,953	0
Later than one year, not later than five years	0	1,950
Later than five years	726	671
Total	2,679	2,621

The estimated annual payments in future years will vary from those which the LHB is committed to make during the next year by the impact of movement in the Retail Prices Index.

25.4 Number of PFI contracts

	Number of on SoFP PFI contracts	Number of off SoFP PFI contracts
Number of PFI contracts	3	0
Number of PFI contracts which individually have a total commitment > £500m	0	0

PFI Contract	On / Off-statement of financial position
Number of PFI contracts which individually have a total commitment > £500m	0

25.5 The LHB has no Public Private Partnerships

26. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. The LHB is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which these standards mainly apply. The LHB has limited powers to invest and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the LHB in undertaking its activities.

Currency risk

The LHB is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The LHB has no overseas operations. The LHB therefore has low exposure to currency rate fluctuations.

Interest rate risk

LHBs are not permitted to borrow. The LHB therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the LHB's funding derives from funds voted by the Welsh Government the LHB has low exposure to credit risk.

Liquidity risk

The LHB is required to operate within cash limits set by the Welsh Government for the financial year and draws down funds from the Welsh Government as the requirement arises. The LHB is not, therefore, exposed to significant liquidity risks.

27. Movements in working capital

	2023-24 £000	2022-23 £000
(Increase)/decrease in inventories	**(268)**	(850)
(Increase)/decrease in trade and other receivables - non-current	**(66,541)**	48,026
(Increase)/decrease in trade and other receivables - current	**15,588**	(18,413)
Increase/(decrease) in trade and other payables - non-current	**(4,804)**	16,983
Increase/(decrease) in trade and other payables - current	**(19,974)**	(1,166)
Total	**(75,999)**	44,580
Adjustment for accrual movements in fixed assets - creditors	**277**	3,423
Adjustment for accrual movements in fixed assets - debtors	**(34)**	0
Adjustment for accrual movements in right of use assets - creditors	**6,135**	0
Adjustment for accrual movements in right of use assets - debtors	**(24)**	0
Other adjustments	**571**	(21,227)
	(69,074)	26,776

28. Other cash flow adjustments

	2023-24 £000	2022-23 £000
Depreciation	**47,475**	47,415
Amortisation	**2,349**	2,859
(Gains)/Loss on Disposal	**331**	(530)
Impairments and reversals	**10,170**	(19,470)
Release of PFI deferred credits	**0**	0
NWSSP Covid assets issued debited to expenditure but non-cash	**0**	0
Covid assets received credited to revenue but non-cash	**0**	0
Donated assets received credited to revenue but non-cash	**(136)**	(210)
Government Grant assets received credited to revenue but non-cash	**0**	0
Right of Use Grant (Peppercorn Lease) credited to revenue but non cash	**0**	(17)
Non-cash movements in right of use assets	**0**	0
Non-cash movements in provisions	**83,168**	(11,799)
Other movements	**32,067**	28,435
Total	**175,424**	46,683

Other movements are Notional funding received for the

- LHB notional 6.3% Staff Employer Pension Contributions and
- 2019/20 Pensions Annual Allowance Charge Compensation Scheme

funded directly to the NHSBA Pensions Division by Welsh Government.

29. Events after the Reporting Period

These financial statements were authorised for issue by the Chief Executive and Accountable Officer on 11th July 2024; post the date the financial statements were certified by the Auditor General for Wales.

30. Related Party Transactions

The Welsh Government is regarded as a related party. During the year the LHB have had a significant number of material transactions with the Welsh Government and with other entities for which the Welsh Government is regarded as the parent body, namely

	2023-24		As at 31st March 2024	
	Expenditure to related party	Income from related party	Amounts owed to related party	Amounts due from related party
	£000	£000	£000	£000
Welsh Government	65	6,993		
Betsi Cadwaladr University Health Board	1,474	138	293	13
Cardiff & Vale University Health Board	44,303	3,199	2,454	1,181
Cwm Taf University Health Board	22,114	2,657	1,704	1,088
Hywel Dda University Health Board	1,253	346	544	41
Powys Teaching Health Board	373	14,658	62	1,316
Swansea Bay University Health Board	3,762	1,154	906	332
Velindre NHS Trust	85,357	11,055	3,289	5,218
Welsh Ambulance Services NHS Trust	10,305	257	1,803	27
Public Health Wales NHS Trust	1,588	4,253	377	654
Welsh Health Specialised Services Committee	208,689	13,948	4,681	2,911
Health Education and Improvement Wales (HEIW)	40	14,596	7	901
Digital Health and Care Wales (DHCW)	7,549	1,307	32	143

In addition the LHB has had significant number of material transactions with other Government Departments and other central and local Government bodies. The most significant of these transactions are with the following:-

Government Body	2023-24		As at 31st March 2024	
	Expenditure to related party	Income from related party	Amounts owed to related party	Amounts due from related party
	£000	£000	£000	£000
Blaenau Gwent County Borough Council	4,476	1,360	2,952	378
Caerphilly County Borough Council	19,212	13,413	5,524	3,395
Monmouthshire County Council	7,453	1,955	2,421	780
Newport City Council	11,673	2,096	5,328	436
Torfaen County Borough Council	10,684	1,557	3,052	264

The LHB has also had significant material transactions with the following:

Aneurin Bevan Local Health Board Charitable Fund	39	1,257	8	378

A number of the LHB's Board members have interests in related parties as follows:

Member	Related Organisation	Relationship with Related Party	2023-24		As at 31st March 2024	
			Expenditure to related party	Income from related party	Amounts owed to related party	Amounts due from related party
			£000	£000	£000	£000
Nicola Prygodzicz	Velindre NHS Trust	Sister is a Senior Nurse in the Corporate Nursing Team	85,357	11,055	3,289	5,218
Robert Holcombe	JW Bowkett (Electrical Installation) Ltd	Son was an employee until June 2023	536	0	169	0
	Torfaen County Borough Council	Member of Torfaen CBC Land Access Forum	10,684	1,557	3,052	264
Peter Carr	Digital Health & Care Wales	Chair of National Laboratory Information Management Systems 2.0 Programme Board	7,549	1,307	32	143
Philip Robson	Hospice of Valleys	Trustee	475	0	4	0
Richard Clark	Torfaen Voluntary Alliance	Company Secretary and Trustee	142	0	0	0
	Torfaen County Borough Council	Elected Member, Deputy Leader and Executive Member for Children, Families and Education	10,684	1,557	3,052	264
Penny Jones	Monmouthshire County Council	Councillor	7,453	1,955	2,421	780

31. Third Party assets

The LHB held £32,719.58 cash at bank and in hand at 31 March 2024 (31st March 2023, £23,655.85) which relates to monies held by the LHB on behalf of patients. Cash held in patient Investment Accounts amounted to £0 at 31st March 2024 (31st March 2023, £0). This has been excluded from the Cash and Cash equivalents figure reported in the accounts.

In addition the LHB had located on its premises a significant quantity of consignment stock. This stock remains the property of the supplier until it is used. The value of consignment stock at 31 March 2024 amounted to £3.5m (£2.5m as at 31st March 2023).

32. Pooled budgets

The Health Board has five pooled budgets. The specific accounting treatment of each pooled budget is covered within Accounting Policies note 1.22.

Monnow Vale Health and Social Care Unit
The Health Board has entered into a pooled budget with Monmouthshire County Council. Under the arrangement funds are pooled under section 33 of the NHS (Wales) Act 2006 to provide health and social care inpatient, outpatient, clinic and day care facilities to individuals who have medical, social, community or rehabilitation needs and a memorandum note to the accounts provides details of the joint income and expenditure. The asset value of property, plant & equipment is **£5,461K** which is split 72% Aneurin Bevan Health Board and 28% Monmouthshire County Council. The costs incurred under the pooled budget is declared in the memorandum trading account.

Gwent Wide Integrated Community Equipment Service
The Health Board has entered into a pooled budget with the 5 Local Authorities in the Gwent area, namely Blaenau Gwent, Caerphilly, Monmouth, Newport and Torfaen County Borough Councils, for the provision of an effective integrated GWICES (Gwent Wide Integrated Community Equipment Service) to service users who are resident in the partners' localities. Under the arrangement funds are pooled under section 33 of the NHS (Wales) Act 2006 for the joint equipment store in the Gwent area. The Health Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement. The LHB's contribution is **£971K** for 2023/24 (£891K in 2022/23).

Mardy Park Rehabilitation Centre
The Health Board has entered into a pooled budget arrangement with Monmouthshire County Council. Under the arrangement funds are pooled under Section 33 of the NHS (Wales) Act 2006 to provide care to individuals who have rehabilitation needs. The pool is hosted by Monmouthshire County Council and the LHBs contribution is **£272K** for 2023/24 (£223K in 2022/23).

Gwent Frailty Programme
The Health Board has entered into a pooled budget with 5 Local Authorities in the Gwent area, namely Blaenau Gwent , Caerphilly, Monmouthshire, Newport and Torfaen County councils, for the provision of a Gwent wide integrated health and social care Frailty service, for service users who are resident in the partners' localities. Under the arrangement funds are pooled under section 33 of the NHS (Wales) Act 2006 for the purpose of establishing a consistent service for the Gwent area. The Health Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement. The LHB's contribution is **£9,892K** for 2023/24 (£9,493K in 2022/23).

Continuing Healthcare - Older People in Care Homes
The Health Board has entered into a pooled budget with the 5 Local Authorities in the Gwent area, namely Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen County Councils, for the provision and commissioning of certain specialised services for older people (>65 years of age) in a care home setting in Gwent. Statutory Directions issued under section 169 of the Social Services and Wellbeing (Wales) Act 2014 required Partnership Bodies to enter into partnership arrangements and for the establishment and maintenance of pooled funds from April 2018, for the exercise of their Care Home Accommodation Functions.
The pool was established in August 2018 and is hosted by Torfaen County Borough Council. Under the arrangement, the Health Board makes a financial contribution equivalent to related expenditure in commissioning related placements in homes during the year. The LHB's contribution is **£41,298K** for 2023/24 (£36,563K in 2022/23).

Pooled Budget memorandum account for the period 1st April 2023 - 31st March 2024

Monnow Vale

	Cash	Own Contribution	Grants	Total
	£	£	£	£
Funding				
Aneurin Bevan Health Board	0	2,863,450	0	2,863,450
Monmouthshire County Council	425,860	882,742	0	1,308,602
Total Funding	**425,860**	**3,746,192**	**0**	**4,172,052**
Expenditure				
Aneurin Bevan Health Board	0	3,220,491	0	3,220,491
Monmouthshire County Council	658,462	788,398	0	1,446,860
Total Expenditure	**658,462**	**4,008,889**	**0**	**4,667,350**
Net (under)/over spend	**232,602**	**262,697**	**0**	**495,298**

33. Operating segments

IFRS 8 requires bodies to report information about each of its operating segments.

IFRS 8 requires bodies to report information about each of its operating segments.

Whilst the organisation is structured into divisions, the performance management and the allocation of resource flow from the Board of Aneurin Bevan University Health Board.

There are no hosted services within the health board. Divisions do not manage capital programmes, have any autonomy in relation to balance sheets or produce discrete accounts.

For the purposes of IFRS 8 it is therefore deemed that there is no requirement to report any operating segment

34. Other Information

34.1. 6.3% Staff Employer Pension Contributions - Notional Element

The value of notional transactions is based on estimated costs for the twelve month period 1 April 2023 to 31 March 2024. This has been calculated from actual Welsh Government expenditure for the 6.3% staff employer pension contributions between April 2023 and February 2024 alongside Health Board/Trust/SHA data for March 2023.

Transactions include notional expenditure in relation to the 6.3% paid to NHS BSA by Welsh Government and notional funding to cover that expenditure as follows:

	2023-24	2022-23
Statement of Comprehensive Net Expenditure for the year ended 31 March 2024	**£000**	**£000**
Expenditure on Primary Healthcare Services	**662**	585
Expenditure on Hospital and Community Health Services	**31,403**	27,842
Statement of Changes in Taxpayers' Equity For the year ended 31 March 2024		
Net operating cost for the year	**32,065**	28,427
Notional Welsh Government Funding	**32,065**	28,427
Statement of Cash Flows for year ended 31 March 2024		
Net operating cost for the financial year	**32,065**	28,427
Other cash flow adjustments	**32,065**	28,427
2.1 Revenue Resource Performance		
Revenue Resource Allocation	**32,065**	28,427
3. Analysis of gross operating costs		
3.1 Expenditure on Primary Healthcare Services		
General Medical Services	**662**	585
3.3 Expenditure on Hospital and Community Health Services		
Directors' costs	**103**	78
Staff costs	**31,300**	27,764
9.1 Employee costs		
Permanent Staff		
Employer contributions to NHS Pension Scheme	**32,065**	28,427
Charged to capital	**0**	0
Charged to revenue	**32,065**	28,427
18. Trade and other payables		
Current		
Pensions: staff	0	0
28. Other cash flow adjustments		
Other movements	**32,065**	28,427

THE NATIONAL HEALTH SERVICE IN WALES ACCOUNTS DIRECTION GIVEN BY WELSH MINISTERS IN ACCORDANCE WITH SCHEDULE 9 SECTION 178 PARA 3(1) OF THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 (C.42) AND WITH THE APPROVAL OF TREASURY

LOCAL HEALTH BOARDS

1. Welsh Ministers direct that an account shall be prepared for the financial year ended 31 March 2011 and subsequent financial years in respect of the Local Health Boards (LHB)1, in the form specified in paragraphs [2] to [7] below.

BASIS OF PREPARATION

2. The account of the LHB shall comply with:

(a) the accounting guidance of the Government Financial Reporting Manual (FReM), which is in force for the financial year in which the accounts are being prepared, and has been applied by the Welsh Government and detailed in the NHS Wales LHB Manual for Accounts;

(b) any other specific guidance or disclosures required by the Welsh Government.

FORM AND CONTENT

3. The account of the LHB for the year ended 31 March 2011 and subsequent years shall comprise a statement of comprehensive net expenditure, a statement of financial position, a statement of cash flows and a statement of changes in taxpayers' equity as long as these statements are required by the FReM and applied by the Welsh Assembly Government, including such notes as are necessary to ensure a proper understanding of the accounts.

4. For the financial year ended 31 March 2011 and subsequent years, the account of the LHB shall give a true and fair view of the state of affairs as at the end of the financial year and the operating costs, changes in taxpayers' equity and cash flows during the year.

5. The account shall be signed and dated by the Chief Executive of the LHB.

MISCELLANEOUS

6. The direction shall be reproduced as an appendix to the published accounts.

7. The notes to the accounts shall, inter alia, include details of the accounting policies adopted.

Signed by the authority of Welsh Ministers

Signed : Chris Hurst Dated :

1. Please see regulation 3 of the 2009 No.1559 (W.154); NATIONAL HEALTH SERVICE, WALES; The Local Health Boards (Transfer of Staff, Property, Rights and Liabilities) (Wales) Order 2009.

Agenda Item:

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	21 May 2024
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Audit Enquiries Response to Audit Wales
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Rob Holcombe, Director of Finance, Procurement and VBHC
SWYDDOG ADRODD: **REPORTING OFFICER:**	Mark Ross, Assistant Finance Director

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

Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

As part of their annual audit process, Audit Wales have request documented consideration and understanding on a number of governance areas that impact on the audit of the financial statements. These considerations are relevant to both the management of Health Board and those charged with governance (the Board and Audit Committee).

The information provided will inform the auditors' understanding of the Health Board and its business processes and support their work in providing an audit opinion on the 2023-24 financial statements.

Cefndir / Background

As above

Asesiad / Assessment

The completed document is included in the attachment The responses have required input from a number of individuals from the Health Board, in particular, the Director of Corporate Governance, Head of Internal Audit, Head of Counter Fraud and Head of Financial Accounts.

The responses in draft form have been sent to Audit Wales to assist them with their audit.

Argymhelliad / Recommendation

The Committee is asked to note the report for Information.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.5 Record Keeping 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	Choose an item. FInance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	

Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

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

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Mr Rob Holcombe
Executive Director of Finance and Procurement
ABUHB Headquarters
St Cadoc's Hospital
Lodge Road
Newport

Reference: JR/01/AB23-24

Date issued: 3 April 2024

Dear Rob,

Aneurin Bevan UHB: Audit enquiries to those charged with governance and management

The Auditor General's Statement of Responsibilities sets out that he is responsible for obtaining reasonable assurance that the financial statements taken as a whole are free from material misstatement, whether caused by fraud or error. It also sets out the respective responsibilities of auditors, management and those charged with governance.

This letter and the enclosed tables in appendix 1 and 2, formally seek documented consideration and understanding on a number of governance areas that impact on our audit of your financial statements.

Appendices 1 and 2 include the enquiries and management and 'those charged with governance' (the Board and Audit Risk and Assurance Committee) and there is relevant background information in Appendix 3.

The responses you provide will inform our understanding of the Health Board and its business processes and support our work in providing an audit opinion on your 2023-24 financial statements.

The completed tables should be formally considered and communicated to us, on behalf of both management and those charged with governance, by 10 May 2024.

If you have queries, please contact me at julie.rees@audit.wales.

I have copied this letter to Mark Ross and Estelle Evans.

Yours sincerely

Julie Rees
Audit Manager

Appendix 1: Enquiries of management

Enquiries of management – in relation to fraud

Question	2023-24 Response
1. What is management's assessment of the risk that the financial statements may be materially misstated due to fraud? What is the nature, extent and frequency of management's assessment?	The risk of misstatement remains low. The basis being an effective system of internal controls and sound control environment mitigate against the risk. This is supported by 2023/24 Internal Audit reports and the imminent Head of Internal Audit Opinion.
2. Do you have knowledge of any actual, suspected or alleged fraud affecting the audited body?	In the reporting year 2023/24 there has been 72 instances of suspected fraud against ABUHB. These were reported to the Audit Risk and Assurance Committee during this period via interim reports and the end of year reporting. These cases together with some completed cases from the previous financial years have attracted recoveries of £231,711.51. As in previous years these cases were mainly staff related, from instances of working whilst on sick leave, falsification of timesheets/expenses and dishonest retention of erroneous salary overpayments. The remaining cases involved NHS Primary care contractors and patients/members of the public.
3. What is management's process for identifying and responding to the risks of fraud in the audited body, including any specific risks of fraud that management	The processes for identifying and responding to risks around fraud are enhanced by a robust and well-resourced counter fraud programme. The Cabinet

Question	2023-24 Response
has identified or that have been brought to its attention?	Office NHS requirement GOV S013 requires that all counter fraud risk assessments are carried out by the Counter Fraud Team. Following on from the initial assessment all informed Fraud Risk is reviewed by the counter fraud team. This can be achieved via management ownership, post-investigation, thematic exercise, or central NHS trends reported from NHS Counter Fraud Authority (CFA). A thorough assessment is conducted, and recommendations made which are reported to Directorate, Executive Director with responsibility for the risk domain, Executive Director of Finance and Audit Risk and Assurance Committee. The aim of the risk assessment is to fraud proof processes, address any identified weakness and with the goal of reducing the opportunity of fraud in that area to an absolute minimum. All fraud risks remain live on a document within the Counter Fraud department and are subject to regular review but held by the directorate that holds the process and therefore the risk. All completed fraud risks are recorded and reported to the NHS CFA via the case management system (CLUE). All fraud risk work carried out is compliant with the organisations over riding Risk Management Policy and the requirements of Compliance set by the NHS CFA. There is a yearly Counter Fraud Functional Standards returns to the NHS CFA whereby NHS Requirement 3

Question	2023-24 Response
	(GovS 013 component 3 Fraud, bribery, and corruption risk assessment) has to be reported on and in 2023/24 ABUHB achieved green status in the RAG rating. The previous year they were audited by the NHS CFA and achieved a green rating. In addition, there is a Post Payment Verification Panel which evaluates and monitor 'errors' with claims that have been submitted to Primary Care Services by the individual GP Practices and Opticians. All senior staff in the Finance Department must be professionally qualified accountants whose professional institutes have strong codes of conduct and professional ethics. All reported/alleged reports of suspected fraud are routed through to ABUHB's Counter Fraud Team for consideration of investigation and/or referral to NHS Counter Fraud Service Wales team where the significance and complexity of the suspected fraud lends itself to an All-Wales approach. This work is fully reported to the Audit, Risk and Assurance Committee at its regular business meeting in its private/public sessions via the counter fraud progress report. Also, as part of their private meetings, the Board receives minutes from the private meeting of the Audit, Risk and Assurance Committee, which

Question	2023-24 Response
	include reference and any significant points highlighted in the Counter Fraud Progress Reports. ABUHB's senior management team seek and will receive advice from its Counter Fraud team on recommended next steps regarding investigations and prosecutions if appropriate.
4. What classes of transactions, account balances and disclosures have you identified as most at risk of fraud?	Those areas most at risk of fraud can be generally identified in two ways. By severity of consequence or by likelihood. Those areas most at risk of fraud by consequence are Mandate Frauds, Invoice Frauds and Procurement Frauds. These areas are high risk generally due the nature of the fraud and the usual high value that is associated with it. But because the processes in place to combat these are robust and are regularly reviewed and have strict governance the instances are rarer. Those areas most at risk from fraud by likelihood examples of which are payroll fraud and staff overpayments; dual working; working whilst sick and trade creditor duplication. These frauds are generally of lower value and due to the nature of theses frauds are easier to investigate and the subsequent recouping of losses.

Question	2023-24 Response
5. Are you aware of any whistleblowing or complaints by potential whistle blowers? If so, what has been the audited body's response?	In the year 2023/24 ABUHB Counter Fraud Team dealt with one case that involved a whistle blower. This case resulted in a member of staff being formally interviewed and following the staff member is to be cautioned by the Police and subject to the HB's disciplinary process. The whistleblower was protected and supported throughout the investigation. ABUHB has a clear Whistle Blowing Policy that would be adhered to in any instances of whistle blowing by staff or contractors etc. If staff wish to report matters concerning suspected fraud, there are a number of ways of doing this, including utilising the NHS Fraud and Corruption Reporting line and remaining anonymous in doing so. These referrals are then processed by the NHS CFA and passed to ABUHB Head of Counter Fraud via the CLUE system.
6. What is management's communication, if any, to those charged with governance regarding their processes for identifying and responding to risks of fraud?	ABHUB's Head of Counter Fraud reports regularly (as a standing agenda item) to the Public and Private session of the Health Board's Audit, Risk and Assurance Committee. Reports from the Audit, Risk and Assurance Committee are submitted to the Board. If there is a clear conflict of interest for ABUHB or if it involved a very senior staff member the likelihood

Question	2023-24 Response
	would be the matter would be referred to NHS CFS Wales.
7. What is management's communication, if any, to employees regarding their views on business practices and ethical behaviour?	As previously stated in 2022/23's response ABUHB has an agreed Values and Behaviours Framework and Business Conduct Policy. The staff values and behaviour are reinforced via the appraisal process which is linked now to pay progression. Declarations of Interests are sought annually with the expectation that as staff are aware of their duty to disclose this will be done as and when this need arises. All Board members are provided with a direct request regarding completing a Declaration of Interest and are made aware of their continuing duty to declare as and when required to do so.
8. For service organisations, have you reported any fraud to the user entity?	As previously stated, any alleged fraud that is suspected to have occurred within NWSSP is reported directly to their LCFS. As of June 2022, any alleged fraud in NWSSP is now reported to the appointed LCFS for NWSSP. They in turn would investigate any instances of fraud against NWSSP unless the loser was specifically a Health Board and report those matters to their own Audit, Risk and Assurance Committee. The Counter Fraud Team are required to

Question	2023-24 Response
	liaise with internal and external partners on a regular basis. If any fraud is identified by the organisation it is reported to the Counter Fraud Team who would duly investigate it. Should matters arise that concerns other agencies or partners then a close working protocol is adopted in order that all fraud identified is appropriately dealt with. E.g., Overseas Patients and Immigration Services; Taxi Contracts; Universities; nursing and medical staffing agencies. Fraud is regularly reported to other organisations/parties where it has occurred where ABUHB is not necessarily the financial victim of it, such as the DWP, HMRC etc.

Enquiries of management – in relation to laws and regulations

Question	2023-24 Response
9. Is the audited body in compliance with relevant laws and regulations? How have you gained assurance that all relevant laws and regulations have been complied with? Are there any policies or procedures in place?	Compliance with legislation and regulations form part of the scopes of external and internal scrutiny bodies reviews. Compliance with major new or revised legislation and regulation are reported as separate items to various Executive Groups and Board Committees. During the year a series of Welsh Health Circulars and Ministerial Directions were issued to the health board.

Question	2023-24 Response
	Compliance with these is monitored by the corporate governance team and a nominated Director is required to oversee implementation. Assurance on compliance is reported to the Audit, Risk & Assurance Committee and disclosed in the Annual Governance Statement.
10. Have there been any instances of non-compliance or suspected non-compliance with relevant laws and regulations in the financial year, or earlier with an ongoing impact on this year's audited financial statements?	The Health Board currently have an open case with the Health and Safety Executive (HSE). The case relates to a fatal patient fall that occurred in 2019. The HSE have completed their investigation into the matter and have identified possible breaches of legislation by the Health Board. The HSE have yet to make an enforcement decision.
11. Are there any potential litigations or claims that would affect the financial statements?	All relevant information is reflected in the financial statements. The information for this is provided by the solicitors in NWSSP Legal Services who provide a quantum report

Question	2023-24 Response
	which includes estimated settlements/costs, we use this to calculate a provision. The solicitors estimate settlements/costs using their best judgement based on average national settlements, their knowledge of the case and any recent similar settlements.
12. Have there been any reports from other regulatory bodies, such as HM Revenues and Customs which indicate non-compliance?	There have been no issues of non-compliance
13. Are you aware of any non-compliance with laws and regulations within NWSPP since 1 April of the financial year?	No issues to report
14. Have there been any changes to laws and regulations that directly impact the entity this year?	The Health and Social Care (Quality and Engagement) (Wales) Act 2020 became law on 1 June 2020. The Duty of Quality and the Duty of Candour under this Act became effective 1st April 2023. The Duty of Quality includes the new Quality Standards 2023 that replaces the Health and Care Standards (April 2015).

Question	2023-24 Response
15. Has there been any significant communications with regulators?	The Health Board continues to maintain positive relationships with its regulators, including Healthcare Inspectorate Wales and the Health and Safety Executive as well as professional regulators such as GMC and NMC. There are no significant communications to report. Reports issued by the regulators are presented to the Board's Patient Quality, Safety & Outcomes Committee alongside management actions plans for improvements. These reports are disclosed into the public domain
16. For service organisations, have you reported any non-compliance with laws and regulations?	There have been no matters of non-compliance with laws and regulations reported in 2023/24

Enquiries of management – in relation to related parties

Question	2023-24 Response
17. Have there been any changes to related parties from the prior year? If so, what is the identity of the related parties and the nature of those relationships? Confirm these have been disclosed to the auditor.	This is fully reflected in the accounts which includes any changes along with prior period information.

Question	2023-24 Response
18. What transactions have been entered into with related parties during the period? What is the purpose of these transactions? Confirm these have been disclosed to the auditor.	These will be provided as part of the annual accounts and associated statements.
19. What controls are in place to identify, account for and disclose related party transactions and relationships?	There will be provided as part of the annual accounts and associated statements
20. What controls are in place to authorise and approve significant transactions and arrangements: • with related parties, and • outside the normal course of business?	There is an Annual Declarations of Interest process that is completed for all Board Members, standard agenda item on all meetings for disclosure of any Declarations of Interest. Business Conduct Policy in operation

Enquiries of management – in relation to regularity

Question	2023-24 Response
21. What is your assessment of the risk of material irregularity?	There are no known issues in respect of non-compliance with laws or regulations for reporting, as previously stated. The Health Board also has

Question	2023-24 Response
	confidence in its preparation of the financial statements and the data used to inform this. The level of risk of irregularity is therefore deemed very low.
22. What is the process for responding to the risk of irregularity?	A robust process is in place through a comprehensive Internal Audit Plan and annual fraud workplan, both of which are approved and monitored/responded to through the Audit Committee.
23. What is your knowledge of actual, suspected or alleged irregularity?	We are not aware of any
24. Where service organisations are used by the entity, have any irregularities been reported to the user entity?	We are not aware of any

Enquiries of management – in relation to the control environment & IT systems

Question	2023-24 Response
25. If internal control deficiencies were reported in the prior year, please comment on the status of these.	There are no control deficiencies that have been reported that would impact on the financial statements. There are two limited assurance reports from this year so far: 1. Facilities (particularly the stock aspect); and 2. Estates Condition. There have been some reports rated as reasonable assurance overall, but with some objectives within them rated as limited assurance.
26. Have there been any changes to significant IT systems or applications in the period?	The Shared Services Central Team are leading a project to upgrade the current reporting tool – Qlik View (FBI) - to Qlik Sense. The Health Board is heavily involved with the testing of this. The First Phase of the project, which is based on replicating the current information available in FBI, is expected to complete during June 2024 with the Second Phase, which focuses on new developments, then commencing. The data on the older Qlik View system will be available until October 2024.

Question	2023-24 Response
	The project is progressing well with no impact on the financial statements. There are no known significant changes to IT systems or applications in the year that would have any impact on the financial statements

Enquiries of management – in relation to financial reporting

Question	2023-24 Response
27. Are you aware of significant transactions that are outside the normal trading activities of the business?	None
28. Are you aware of any transactions, events or changes in circumstances that would cause impairments of non-current assets?	Impairments in the financial statements are shown in the table below.

AME Impairments on Coming Into Use	Required
Tredegar HWBC	13.404
LGH Well-being Works	0.511
Breast Centralisation YYF	5.796
RGH Endoscopy Unit	5.978

Question	2023-24 Response
	RAAC NHH 3.199 **DEL Impairment** Mar Figure WCCIS Phase 2 0.438
29. Are you aware of any transactions, events and conditions (or changes in these) that may give rise to recognition or disclosure of significant accounting estimates that require significant judgement?	The impact of Junior Doctors' strike action is reflected in the accounts. Given one of these took place over the 31 March period, an estimate has been made based on the information available from the previous 2 strikes. The values are not material.
30. Have there been any changes in accounting policies in relation to significant estimates?	See q 29 above
31. Have you used any experts in the preparation of the accounts?	No experts are used in the preparation of the accounts themselves – that is done by the in-house financial accounts team. However, a range of experts are used to provide information for the accounts in the normal way e.g.

Question	2023-24 Response
	District Valuer, the solicitors in NWSSP Legal Services who provide a quantum report which includes estimated settlements/costs used to calculate a provision.
32. Have there been any issues that may impact the preparation of the accounts identified so far?	The impact of Junior Doctors' strike action is reflected in the accounts. Given one of these took place over the 31 March period, an estimate has been made based on the information available from the previous 2 strikes. The values are not material.
33. Do you have knowledge of events or conditions beyond the period of the going concern assessment that may cast significant doubt on the entity's ability to continue as a going concern?	Cash has been and continues to be available. This is evidenced by the >95% payment of invoices within 30 days. Welsh Government have made adequate cash available to cover the financial deficit during the year and we fully expect that to continue.

Appendix 2: Enquiries of those charged with governance

Enquiries of those charged with governance – in relation to fraud

Question	2023-24 Response
1. Do you have any knowledge of actual, suspected or alleged fraud affecting the audited body?	Throughout 2023/24 there has been numerous reported frauds (72) that have affected ABUHB. Some of these cases has resulted in criminal action by way of Police Caution but the majority have been dealt with by way of internal disciplinary and the referral to the relevant professional body for their consideration. The outcome of their standards and conduct hearings are then awaited. The LCFS assists in both these processes.
2. What is your assessment of the risk of fraud within the audited body, including those risks that are specific to the audited body's business sector?	The assessment of risk is reflected in the Counter Fraud annual work plan, designed to target those areas with most consequence and likelihood and therefore the plan targets the areas where the Health Board is at most risk Aligned with the Government Functional Standards and the Counter Fraud Annual Workplan, the ABUHB Counter Fraud team have a requirement to undertake detection activity to reduce the risk/potential exposure to fraud loss. The Counter Fraud team will target service areas considered/highlighted to be at risk, will evaluate the systems and procedures in, identify potential

Question	2023-24 Response
	weaknesses and ensure that protocols in place are robust. The high priority service areas at risk of exposure include Accounts Payable/Mandate Fraud, Procurement and Recruitment. Comprehensive risk assessments will be undertaken with follow-up local proactive exercises to evaluate the effectiveness and address any evolving system weaknesses.
3. How do you exercise oversight of: • management's processes for identifying and responding to the risk of fraud in the audited body, and • the controls that management has established to mitigate these risks?	Counter Fraud throughout NHS Wales and NHS CFA allows for the immediate sharing of information of new and emerging fraud trends. These fraud risks can then be actioned, and processes altered or put in place to minimise the loses via this type of fraud. The Post Payment Verification team is itself a process to minimise the risk of fraud from NHS contractors. This service is offered as a control measure NHS Wales wide, provided by NWSSP. They identify and investigate anomalies with GP and Opticians payments. They will take the appropriate action as and when required to recoup monies and if required legal action. The very existence of this team is a deterrent. They work closely with LCFS teams and have regular meetings to discuss emerging fraud issues. They also regularly update the Audit, Risk and Assurance Committee. The Audit, Risk and Assurance Committee are themselves duty bound to report any potential Risk of

Question	2023-24 Response
	Fraud within ABUHB. They are reported to by External Audit, Internal Audit and Counter Fraud Services. The Counter Fraud service have an "in confidence" session during the year with the Independent Members of the Audit, Risk & Assurance Committee and Director of Corporate Governance. The Audit, Risk and Assurance Committee also receives regular updates on fraud cases and all actions taken. They are informed about system failures and actions and processes taken, following a comprehensive risk assessment is completed to mitigate further losses

Enquiries of those charged with governance – in relation to laws and regulations

Question	2023-24 Response
4. Are you aware of any non-compliance with laws and regulations that may be expected to have a fundamental effect on the operations of the entity?	There are no issues to report
5. How does the Audit Committee in your role as those charged with governance, obtain assurance that all relevant laws and regulations have been complied with?	As the Board itself is charged with governance, including those elements delegated to the Audit, Risk & Assurance Committee, a range of mechanisms are in place across the breadth of the Board and its committees (including Finance & Performance; Patient Quality, Safety and Outcomes; People and Culture; Remuneration & Terms of Service etc.) to seek assurance that all relevant laws and regulations have been complied with. These include an integrate risk and assurance reporting arrangements, scrutiny arrangements, internal and external Audit. The Audit, Risk & Assurance Committee itself maintains focus on the effectiveness of the health board's risk and assurance framework, to ensure matters of compliance are focussed on across the spectrum of the Board' committees. In 2023/24 the health board received reasonable assurance from its Internal Audit Service in respect of its assurance framework and risk management arrangements.

Enquiries of those charged with governance – in relation to related parties

Question	2023-24 Response
6. How does the Audit Committee, in its role as those charged with governance, exercise oversight of management's processes to identify, authorise, approve, account for and disclose related party transactions and relationships?	There is an Annual Declarations of Interest process and Business Conduct Policy in operation. The Financial statements include a dedicated section in regard to related party relationships where disclosures are made for related party transactions/relationships. Arrangements for declarations of interest are also disclosed in the Annual Governance, reviewed by the Committee.

Enquiries of those charged with governance – supplementary queries

Question	2023-24 Response
7. Are you aware of any actual, suspected or alleged irregularity affecting the entity?	There are none known for reporting.

Question	2023-24 Response
8. Are there any matters which those charged with governance consider require particular attention during the audit?	All issues regarding the financial statements have been raised throughout the year and fully disclosed to the auditors. These are described in earlier answers.
9. Are those charged with governance aware of any significant communications with regulators?	Yes. Reports issued by regulators are presented to the Board's Patient Quality, Safety & Outcomes Committee alongside management actions plans for improvements. These reports are disclosed into the public domain. A report from each meeting of the Patient Quality, Safety & Outcomes Committee is reported to the Board.

Appendix 3: Background information

Matters in relation to fraud

International Standard for Auditing (UK) 240 covers auditors' responsibilities relating to fraud in an audit of financial statements. This standard has been revised for 2022-23 audits.

The primary responsibility to prevent and detect fraud rests with both management and 'those charged with governance', which for the Health Board is the Board. Management, with the oversight of those charged with governance, should ensure there is a strong emphasis on fraud prevention and deterrence and create a culture of honest and ethical behaviour, reinforced by active oversight by those charged with governance.

As external auditors, we are responsible for obtaining reasonable assurance that the financial statements are free from material misstatement due to fraud or error. We are required to maintain professional scepticism throughout the audit, considering the potential for management override of controls.

What are we required to do?

As part of our risk assessment procedures we are required to consider the risks of material misstatement due to fraud. This includes understanding the arrangements management has put in place in respect of fraud risks. The ISA views fraud as either:

- The intentional misappropriation of assets (cash, property, etc); or
- The intentional manipulation or misstatement of the financial statements.

We also need to understand how those charged with governance exercises oversight of management's processes. We are also required to make enquiries of both management and those charged with governance as to their knowledge of any actual, suspected or alleged fraud, management's process for identifying and responding to the risks and the internal controls established to mitigate them.

Matters in relation to laws and regulations

International Standard for Auditing (UK and Ireland) 250 covers auditors' responsibilities to consider the impact of laws and regulations in an audit of financial statements.

Management, with the oversight of those charged with governance, is responsible for ensuring that the Health Board ‘s operations are conducted in accordance with laws and regulations, including compliance with those that determine the reported amounts and disclosures in the financial statements.

As external auditors, we are responsible for obtaining reasonable assurance that the financial statements are free from material misstatement due to fraud or error, taking into account the appropriate legal and regulatory framework. The ISA distinguishes two different categories of laws and regulations:

- laws and regulations that have a direct effect on determining material amounts and disclosures in the financial statements;
- other laws and regulations where compliance may be fundamental to the continuance of operations, or to avoid material penalties.

What are we required to do?

As part of our risk assessment procedures we are required to make enquiries of management and those charged with governance as to whether the Health Board is in compliance with relevant laws and regulations. Where we become aware of information of non-compliance or suspected non-compliance we need to gain an understanding of the non-compliance and the possible effect on the financial statements

Matters in relation to related parties

International Standard for Auditing (UK) 550 covers auditors’ responsibilities relating to related party relationships and transactions.

The nature of related party relationships and transactions may, in some circumstances, give rise to higher risks of material misstatement of the financial statements than transactions with unrelated parties.

Because related parties are not independent of each other, many financial reporting frameworks establish specific accounting and disclosure requirements for related party relationships, transactions and balances to enable users of the financial statements to understand their nature and actual or potential effects on the financial statements. An understanding of the entity's related party relationships and transactions is relevant to the auditor's evaluation of whether one or more fraud risk factors are present as required by ISA (UK and Ireland) 240, because fraud may be more easily committed through related parties.

What are we required to do?

As part of our risk assessment procedures, we are required to perform audit procedures to identify, assess and respond to the risks of material misstatement arising from the entity's failure to appropriately account for or disclose related party relationships, transactions or balances in accordance with the requirements of the framework.

Matters in relation to regularity

International Standard for Auditing (UK and Ireland) 250 covers auditors' responsibilities to consider the regularity of the organisation's transactions.

Regularity is the concept that transactions that are reflected in the financial statements of an audited entity must be in accordance with the relevant framework of authorities.

Frameworks of authorities are external frameworks, specific to an audited entity, with which the audited entity's transactions must conform. These frameworks are set up by bodies able to issue and/or enforce the authorities for that entity and might include, for example:

- authorising legislation;
- regulations issued under governing legislation;
- parliamentary authorities; and
- government or related authorities (for example Managing Welsh Public Money, issued by the Welsh Government).

Further information is available in Practice Note 10.

What are we required to do?

The Practice Note includes an overview, from page 56 of the Practice Note, of what we are required to do.

Internal Audit Progress Report

Audit, Risk and Assurance Committee

May 2024

Aneurin Bevan University Health Board

NWSSP Audit and Assurance Services

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1. Introduction

The purpose of this report is to:

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

2. Progress against the 2023/24 Internal Audit Plan

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

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

Number of audits in plan:	29
Additional review: Facilities	1
Less: deferred audits	(3)
Revised total	27
Number of audits reported as final	17
Number of audits reported as draft	7
Number of audits work in progress	3

The following 2023/24 final reports have been issued since the meeting of the Audit, Risk and Assurance Committee on 16th April 2024:

AUDIT ASSIGNMENT	**ASSURANCE RATING**
Early Supported Discharge - Stroke	Substantial
Maternity (Action Plan)	Substantial
Medical Equipment and Devices	Reasonable
Bevan Health and Wellbeing Centre	Limited

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

3. Summary of Findings

Limited assurance reports are considered by the Audit, Risk and Assurance Committee in detail. The following summary provides the Committee with the main messages from the reports issued since the last meeting on 16th April 2024.

Early Supported Discharge - Stroke (substantial assurance)

The overall objective of the audit was to assess whether the arrangements in place for the early supported discharge of stroke patients are operating effectively.

We found good arrangements in place, with a team that supported the early supported discharge process and ensured prompt engagement with patients. There are a range of support services available, to assist with the patients' rehabilitation within a home environment.

Maternity (Action Plan) (substantial assurance)

This audit focussed on the governance arrangements in place to assist with the tracking of progress of maternity related actions from key recent external reviews. We also sample tested actions and associated evidence to see whether appropriate progress is being made.

Overall, within the sample tested we found regular monitoring and reporting in place, including to appropriate committees. We also confirmed that progress has been made towards the implementation of actions sampled.

Medical Equipment and Devices (reasonable assurance)

This audit provided an opinion over the management and tracking of ultrasound devices only, throughout the Health Board.

Overall, whilst we found good governance architecture around the Health Board's medical equipment reviewed, sample testing of items revealed a number of weaknesses in equipment records management and accuracy. However, the RFID asset tagging process underway has assisted (and will continue to do so) with the tracking of ultrasound devices.

Bevan Health and Wellbeing Centre (limited assurance)

The audit sought to review the delivery and management arrangements in place to progress the Bevan Health & Wellbeing Centre.

We recognised the significant delays to the delivery of the project (currently circa 49.6 weeks) which are attributed to the Supply Chain Partner (SCP). There will therefore be a corresponding delay in achieving the anticipated business case objectives.

The project was also forecast to be £828k (4.2%) over the approved budget, £478k of which had already been funded from the discretionary capital programme for 2023/24 with the remaining overspend to be funded from the University Health Board's (UHB) 2024/25 discretionary capital allocation.

At the time of the review, discussions were ongoing with Welsh Government regarding extra funding – particularly as a significant element of cost increase was associated with unfunded inflationary uplifts.

The SCP delays outlined above have allowed the UHB to apply and continue to apply damages for the period from expected completion to the revised completion date. The SCP is disputing the attestation of culpability for the delays with the associated costs estimated to range between £2.58 and £4.51m. Welsh Government has been fully briefed and the UHB has engaged legal advice on the matter.

The project faces significant challenges going forward as the contractor is likely to be operating at a loss – accordingly, maintaining reasonable performance from the SCP through existing project management tools will be essential through to completion and handover.

4. 2024/25 Internal Audit Plan

The 2024/25 Draft Internal Audit Plan (the 'Plan') was presented to the April 2024 Audit, Risk and Assurance Committee. It is included for formal approval at the May 2024 Committee.

5. 2023/24 Draft Head of Internal Audit Opinion

The 2023/24 Draft Head of Internal Audit Opinion is presented to this Audit, Risk and Assurance Committee and whilst the final position may still change, it is currently expected to be in line with the previous indication provided.

6. Other Activity

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

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

7. Recommendation

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

Appendix A: Progress against 2023/24 Internal Audit Plan

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

Appendix B: Audit Assurance Ratings

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

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

Head of Internal Audit Opinion & Annual Report 2023/2024

mai 2024

Aneurin Bevan University Health Board

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Appendix A Conformance with Internal Audit Standards
Appendix B Audit Assurance Ratings

Report status:	Draft
Draft report issued:	10th May 2024
Final report issued:	XXXX
Author:	Head of Internal Audit
Executive Clearance:	Director of Corporate Governance
Audit, Risk and Assurance Committee:	July 9th 2024

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.

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

1. EXECUTIVE SUMMARY

1.1 Purpose of this Report

Aneurin Bevan University Health Board (the 'Health Board') is accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is also responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. A key element in that flow of assurance is the overall assurance opinion from the Head of Internal Audit.

This report sets out the Head of Internal Audit Opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance and an assessment of conformance with the Public Sector Internal Audit Standards.

1.2 Head of Internal Audit Opinion 2023-24

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Chief Executive as Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. The approved Internal Audit plan is focused on risk and therefore the Board will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement. The overall opinion for 2023/24 is that:

Reasonable assurance		The Board can take **Reasonable Assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

1.3 Delivery of the Audit Plan

The plan has been delivered substantially in accordance with the agreed schedule. Changes required during the year have been approved by the Audit, Risk and Assurance Committee (the 'Committee'). In addition, regular audit progress reports have been submitted to the Committee. Although changes have been made to the plan during the year, we can confirm that we have undertaken sufficient audit work during the year to be able to give an overall opinion in line with the requirements of the Public Sector Internal Audit Standards.

The Internal Audit Plan for 2023/24 year was initially presented to the Committee in April 2023. Changes to the plan have been made during the course of the year and these changes have been reported to the Committee as part of our regular progress reporting.

There are, as in previous years, audits undertaken at NWSSP that support the overall opinion for NHS Wales health bodies (see section 3).

Our latest External Quality Assessment (EQA), conducted by the Chartered Institute of Public Finance and Accountancy in March 2023, and our own annual Quality Assurance and Improvement Programme (QAIP) have both confirmed that our internal audit work 'fully conforms' to the requirements of the Public Sector Internal Audit Standards (PSIAS) for 2023/24. We are able to state that our service 'fully conforms to the IIA's professional standards and to PSIAS'.

1.4 Summary of Audit Assignments

This report summarises the outcomes from our work undertaken in the year. In some cases, audit work from previous years may also be included and where this is the case, details are given. This report also references assurances received through the internal audit of control systems operated by other NHS Wales organisations (again, see section 3).

The audit coverage in the plan agreed with management has been deliberately focused on key strategic and operational risk areas; the outcome of these audit reviews may therefore highlight control weaknesses that impact on the overall assurance opinion.

Overall, we can provide the following assurances to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the areas in the table below.

Where we have given Limited Assurance, management are aware of the specific issues identified and have agreed action plans to improve control in these areas. These planned control improvements should be referenced in the Annual Governance Statement where it is appropriate to do so.

A summary of the audits undertaken in the year and the results are summarised in table 1 below.

Table 1 – Summary of Audits 2023/24

Substantial Assurance	Reasonable Assurance
• Financial Controls • Integrated Performance Dashboard – Data Quality • Early Supported Discharge – Stroke • Maternity Services - Action Plan • Stakeholder Engagement on IT Projects • IAP: YYF Breast Care Services	• Asset Management • Medical Equipment and Devices • Risk Management and Assurance • Integrated Medium Term Plan • Business Continuity Planning • Safeguarding • Waiting List Management • Directorate Review – Theatres • Clinical Coding • Intra-site Patient Transfers • Long Term Sickness Absence Management • Network Infrastructure (VPN) • LINC Programme
Limited Assurance	**Advisory/Non-Opinion**
• Bevan Health and Wellbeing Centre • Estates Assurance – Estates Condition • Facilities Bank Approval Process	• Follow-up of High Priority Recommendations • Flexible Working
Draft Reporting / Work in Progress	
• Savings Programmes • Providing Care to Asylum Seekers • Decarbonisation • Regional Partnership Board • IAP: Newport East audit • IAP: Nevill Hall Radiotherapy audit	

Please note that our overall opinion has also taken into account information obtained during the year that we deem to be relevant to our work (see section 2.4.2).

2. HEAD OF INTERNAL AUDIT OPINION

2.1 Roles and Responsibilities

The Board is collectively accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is a statement made by the Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control, as evidenced by a description of the risk management and review processes, including compliance with the Health & Care Quality Standards; and
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures, together with assurances that actions are or will be taken where appropriate to address issues arising.

The Health Board's risk management process and system of assurance should bring together all of the evidence required to support the Annual Governance Statement.

In accordance with the Public Sector Internal Audit Standards (PSIAS), the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. This is achieved through an audit plan that has been focussed on key strategic and operational risk areas and known improvement opportunities, agreed with executive management and approved by the Audit, Risk and Assurance Committee, which should provide an appropriate level of assurance.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the Health Board. The opinion is substantially derived from the conduct of risk-based audit work formulated around a selection of key organisational systems and risks. As such, it is a key component that the Board takes into account but is not intended to provide a comprehensive view.

The Board, through the Audit, Risk and Assurance Committee, will need to consider the Head of Internal Audit opinion together with assurances from other sources including reports issued by other review bodies, assurances given by management and other relevant information when forming a

rounded picture on governance, risk management and control for completing its Governance Statement.

2.2 Purpose of the Head of Internal Audit Opinion

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Board of Aneurin Bevan University Health Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control.

This opinion will in turn assist the Board in the completion of its Annual Governance Statement and may also be taken into account by regulators and by Audit Wales in the context of both their external audit and performance reviews.

The overall opinion by the Head of Internal Audit on governance, risk management and control results from the risk-based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

2.3 Assurance Rating System for the Head of Internal Audit Opinion

The overall opinion is based primarily on the outcome of the work undertaken during the course of the 2023/24 audit year. We also consider other information available to us such as our overall knowledge of the organisation, the findings of other assurance providers and inspectors, and the work we undertake at other NHS Wales organisations. The Head of Internal Audit considers the outcomes of the audit work undertaken and exercises professional judgement to arrive at the most appropriate opinion for each organisation.

A quality assurance review process has been applied by the Director of Audit and Assurance and the Head of Internal Audit in the annual reporting process to ensure the overall opinion is consistent with the underlying audit evidence.

We take this approach into account when considering our assessment of our compliance with the requirements of PSIAS.

The assurance rating system based upon the colour-coded barometer and applied to individual audit reports remains unchanged. The descriptive narrative used in these definitions has proven effective in giving an objective and consistent measure of assurance in the context of assessed risk and associated control in those areas examined.

This same assurance rating system is applied to the overall Head of Internal Audit opinion on governance, risk management and control as to individual assignment audit reviews. The assurance rating system together with definitions is included at **Appendix B**.

The individual conclusions arising from detailed audits undertaken during the year have been summarised by the assurance ratings received. The aggregation of audit results gives a better picture of assurance to the Board and also provides a rational basis for drawing an overall audit opinion. However, please note that for presentational purposes we have shown the results using the eight assurance domains that were used to frame the audit plan at its outset (see section 2.4.2).

2.4 Head of Internal Audit Opinion

2.4.1 Scope of opinion

The scope of my opinion is confined to those areas examined in the risk-based audit plan which has been agreed with senior management and approved by the Audit, Risk and Assurance Committee. The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement. The Head of Internal Audit opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control is set out below.

Reasonable Assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

This opinion will need to be reflected within the Annual Governance Statement along with confirmation of action planned to address the issues raised.

2.4.2 Basis for Forming the Opinion

The audit work undertaken during 2023/24 and reported to the Audit, Risk and Assurance Committee has been aggregated at Section 5.

The evidence base upon which the overall opinion is formed is as follows:

- An assessment of the range of individual opinions and outputs arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Audit, Risk and Assurance Committee throughout the year. In addition, and where appropriate, work at either draft report stage or in progress but substantially complete has also been considered, and where this is the case then it is identified in the report. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements (see section 2.4.3).

- The results of any audit work related to the Health & Care Quality Standards including, if appropriate, the evidence available by which the Board has arrived at its declaration in respect of the self-assessment for the leadership standard. .
- Other assurance reviews which impact on the Head of Internal Audit opinion including audit work performed at other organisations (see Section 3).
- Other knowledge and information that the Head of Internal Audit has obtained during the year including cumulative information and knowledge over time; observation of Board and other key committee meetings; meetings with Executive Directors, senior managers and Independent Members; the results of *ad hoc* work and support provided; liaison with other assurance providers and inspectors; research; and cumulative audit knowledge of the organisation that the Head of Internal Audit considers relevant to the Opinion for this year.

As stated above, these detailed results have been aggregated to build a picture of assurance across the organisation.

In reaching this opinion we have identified that the majority of reviews during the year concluded positively.

From the opinions issued during the year, three were allocated Substantial Assurance, eighteen were allocated Reasonable Assurance and six were allocated Limited Assurance. No reports were allocated a 'no assurance' opinion. We also issued five reports that were not rated.

In addition, the Head of Internal Audit has considered residual risk exposure across those assignments where limited assurance was reported. Further, the Head of Internal Audit has considered the impact where audit assignments planned this year did not proceed to full audits following preliminary planning work and these were either: removed from the plan; removed from the plan and replaced with another audit; or deferred until a future audit year. The reasons for changes to the audit plan were presented to the Audit, Risk and Assurance Committee for consideration and approval. Notwithstanding that the opinion is restricted to those areas which were subject to audit review, the Head of Internal Audit has considered the impact of changes made to the plan when forming their overall opinion.

A summary of the findings is shown below. We have reported the findings using the eight areas of the Health Board's activities that we use to structure both our 3-year strategic and 1-year operational plans.

Corporate Governance, Risk Management and Regulatory Compliance

We have undertaken **two** reviews in this area.

We completed a review of **Risk Management and Assurance** (reasonable assurance) where we assessed the risk management arrangements within the digital directorate. Overall, we found good arrangements in place, but identified that an overarching directorate risk register should be compiled and Datix utilised, when upgrades to the software have been completed.

We completed the **Follow-up of High Priority Recommendations** review (not rated) where we assessed if high priority (and other significant) recommendations from within an appropriate period had been implemented, together with the Recommendation Tracker being updated accordingly. Overall, we found the process for updating the Recommendation Tracker and extending recommendation deadlines is clear.

Strategic Planning, Performance Management & Reporting

We have undertaken **two** reviews in this area.

The **Integrated Medium Term Plan** audit (reasonable assurance) was undertaken over the controls to ensure the delivery of the IMTP / 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.

The overall objective of the **Integrated Performance Dashboard – Data Quality** audit (substantial assurance) was to assess the accuracy of data utilised within the Integrated Performance Report (IPR) dashboard. In particular, we focused on the accuracy of a sample of data used within the reporting of key metrics within the IPR dashboard i.e. that the source data utilised was consistent with the figures within the dashboard.

We found no data quality issues within the IPR dashboard, but we did note that compilation is largely a process of transcription from monthly data values provided by teams within the Health Board or taken from national data tables.

Financial Governance and Management

We have undertaken **four** reviews in this area.

We completed an audit of **Financial Controls** (substantial assurance) over a sample of key financial controls within the Treasury function.

We completed an audit of **Asset Management** (reasonable assurance) to assess the effectiveness of the Health Board's processes to create and maintain accurate and up-to-date records of its equipment assets. In particular, we focused on the rollout of the RFID asset tagging process.

We noted the asset register relies on manual processes for data capture and updating. This uses both paper flows from asset owners advising of additions, disposals and asset movements and capital spend analysis to update the equipment asset register. However, we found delays in the receipt of these change forms, potentially leading to register inaccuracy. However, the radio frequency (RFID) asset tagging process, which has now reached 67% of the eligible equipment base with a plan to complete by March 2025, improves asset management and, in particular, facilitates asset physical verification. However, as with the manual process, we found weaknesses persist around equipment disposal management, where controls need strengthening.

We provided and opinion over the **Financial Controls – Regional Partnership Board** where we examined the compliance with the Model Standing Orders Reservation and Delegation of Power / Standing Financial Instructions (SFIs) / Financial Control Procedures (FCPs) of the Health Board, regarding Regional Partnership Board (RPB) payments made on behalf of the RPB, by the Health Board.

We completed an audit of **Savings Programmes.**

Quality & Safety

We have undertaken **four** reviews in this area.

The audit of **Early Supported Discharge – Stroke** (substantial assurance) tested the process for supporting patients that may be suitable for rehabilitation within the community. Overall, we found that, within the sample tested, there is a suitably documented and managed service that provided prompt rehabilitation to applicable patients that had suffered a stroke within the previous 12 weeks.

We found an appropriate resourced team to meet the patients' requirements promptly, where typically a triage is completed within approximately 24 to 48 hours of hospital discharge.

The audit of **Safeguarding** (reasonable assurance) 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 found good arrangements and controls over the applicable processes, with allegations actioned appropriately. However, we raised recommendations over ensuring the timely completion of a safeguarding form, developing a Delivery Plan for Level Three Safeguarding training and a regular review / update of case files.

The **Clinical Coding** review (reasonable assurance) provided an opinion over the timely recording of Finished Consultant Episodes (FCE), in accordance with clinical coding standards.

We found the internal and external auditing of the function coding accuracy was seen to exceed target rates. However, we identified a number of weaknesses in the arrangements and processes, which are adversely

affecting the generation of timely and complete management information. We noted the potential impact of inconsistencies with the structure and content of patient records, in particular, the efficiency of the coding activity. We also found that only a small percentage of the backlog of cases not processed in their designated month are processed in subsequent months and as a result significant volumes remain uncoded, although there were periodic recovery exercises completed to reduce the outstanding activity.

The **Maternity Services - Action Plan** (substantial assurance) audit was an assessment of the governance arrangements in place to monitor the implementation of external actions raised across several reviews.

The audit ascertained the external reviews that have taken place recently and the associated actions required. These were incorporated into the Maternity and Neonatal Services in Wales Assessment, Assurance and Exception tool which was compiled by the Welsh Government. Whilst this recorded all relevant actions it was superseded by the Improving together for Wales: Maternity Neonatal Safety Support Programme Cymru Discovery Phase Report. The report included timeframes for the delivery of each action which included short term, medium term and long-term timeframes.

The audit also reviewed a sample of actions and associated evidence to see whether appropriate progress is being made.

Overall, within the sample tested we found regular monitoring and reporting in place, including to appropriate committees. We also confirmed that progress has been made with the implementation of the actions sampled.

Information Governance & Security

We have undertaken **three** reviews in this area.

The **Stakeholder Engagement on IT Projects** audit (substantial assurance) assessed the framework in place for stakeholder engagement on key IT projects. We found guidance in place for programme and project management that includes stakeholder engagement and templates for stakeholder communication. Stakeholders are engaged with at early stages with needs fed into requirement specifications. There is appropriate stakeholder involvement in the governance structures, which enables ownership of projects and programmes and users are included within the testing stages and project and programme sign off.

The **IT Infrastructure** audit (reasonable assurance) determined the adequacy of the systems and controls in place for the management of the network and IT Infrastructure assets.

We found good arrangements in place, but raised several recommendations.

The **LINC Programme** audit (reasonable assurance) reviewed the arrangements in place for the mitigation of risk associated with the non or late delivery of the LINC programme of work.

Overall, the key risk associated with the delay to the LINC programme is being appropriately mitigated against through the contingency project; LIMS 2.0. Our review highlighted that the key risk is reflected within both project and directorate risk registers.

Whilst other project-level risks associated with the delay have been appropriately identified and are well-managed, we noted inadequate risk management arrangements within the Pathology directorate.

Operational Service and Functional Management

We have undertaken **seven** reviews in this area.

The **Medical Equipment and Devices** audit (reasonable assurance) assessed the management and tracking of ultrasound devices throughout the Health Board. Overall, whilst we found good governance architecture around the Health Board's medical equipment reviewed, sample testing of items revealed a number of weaknesses in equipment records management and accuracy.

The **Business Continuity Planning** audit (reasonable assurance) audit of the arrangements that the Health Board has in place to maintain business continuity in the event of a critical incident, including how learnings from the Covid-19 pandemic have been considered.

We focused on the role of the business continuity team and how embedded business continuity is across the Health Board. We found detailed guidance in place as required by the Civil Contingencies Act 2004. Within our sample of seven services areas, we found six had continuity plans in place, with one still in the process of being developed.

We raised recommendations over the testing of plans and action cards, in addition to staff training and incorporating actions from post pandemic reviews into operational plans.

The **Waiting List Management** audit established whether all patients on the waiting list have been assessed and assigned an appropriate priority rating in line with the Royal College of Surgeons guidance, including suitable arrangements for communicating and supporting patients.

The Directorate Review – Theatres (reasonable assurance) provided an opinion over the effectiveness of the health boards processes to manage and monitor theatre stocks.

The **Intra-site Patient Transfer** (reasonable assurance) audit has been undertaken to provide an opinion over the management of intra-site patient transfers.

A review of **Providing Care to Asylum Seekers** was completed.

The **Facilities Bank Approval Process** audit (limited assurance) assessed whether appropriate stock processes are in place and whether applicable controls within the process for allocating / approving bank shifts are effective.

Whilst we raised a recommendation over retrospective bank shifts, the main risks identified were associated with the management of stock within the Facilities Division. We raised numerous recommendations regarding procedures, non-compliance with the Health Board's stock management policies, unknown stock levels and insufficient waste management awareness.

Workforce Management

We have undertaken **two** reviews in this area.

The **Long Term Sickness Absence Management** audit (reasonable assurance) sought to provide assurance that the NHS Wales Managing Absence at Work Policy was being adhered to. We found within the sample tested that the policy is primarily being applied correctly, alongside additional actions to aid staff in implementing the policy. These actions include training, sickness absence groups and deep dives to assist with the design of action plans.

The **Flexible Working** advisory review (not rated) assessed the Health Board's progress in embedding flexible working practices and identification of good practice.

Capital & Estates Management

We have undertaken **six** reviews in this area.

The **YYF Breast Care Services** audit (substantial assurance) reviewed the arrangements in place to progress the Ysbyty Ystrad Fawr Unified Breast Unit. in the period after the prior audit which was completed in December 2022.

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

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

Generally, the audit observed sound controls and good compliance across the assurance objectives. The project was delayed by 12 months from its intended start date, primarily due to the change in market conditions and the withdrawal of the main sub-contractor's original cost submission. Accordingly, costs have been revised due to these changes with additional funding sought, and approved, by the Welsh Government. Budgeted costs were aligned with the revised funding, with no variance anticipated to date.

However, we raised recommendations to establish roles and responsibilities, improve the interaction of commercial meetings and to enhance the management and monitoring of key risks.

The **Decarbonisation** review (work in progress) was undertaken to determine if the Health Board was adhering to the Welsh Government's requirements for the achievement of net zero carbon emissions.

The **Bevan Health and Wellbeing Centre audit** (limited assurance) sought to review the delivery and management arrangements in place to progress the Bevan Health and Wellbeing Centre.

This assessment primarily recognises the significant delays to the delivery of the project (currently circa 49.6 weeks) which are attributed to the Supply Chain Partner (SCP). There will therefore be a corresponding delay in achieving the anticipated business case objectives.

The project was also forecast to be £828k (4.2%) over the approved budget, £478k of which had already been funded from the discretionary capital programme for 2023/24 with the remaining overspend to be funded from the University Health Board's (UHB) 2024/25 discretionary capital allocation.

At the time of the review, discussions were ongoing with Welsh Government (WG) regarding extra funding – particularly as a significant element of cost increase was associated with unfunded inflationary uplifts.

The SCP delays outlined above have allowed the UHB to apply and continue to apply damages for the period from expected completion to the revised completion date.

The SCP is disputing the attestation of culpability for the delays with the associated costs estimated to range between £2.58 and £4.51m. Welsh Government has been fully briefed and the UHB has engaged legal advice on the matter.

The project faces significant challenges going forward as the contractor is likely to be operating at a loss – accordingly, maintaining reasonable performance from the SCP through existing project management tools will be essential through to completion and handover.

The **Estates Assurance – Estates Condition audit** (limited assurance) The audit sought to evaluate the arrangements put in place by the UHB to identify and manage key risks associated with the existing estate and the implementation of resulting strategies to manage/mitigate the risk.

A full survey of the estate was last undertaken in 2017 (a refresh now overdue, being beyond the recommended five-year interval). In the interim, "high" risk backlog has increased from an assessed £200,000 to over £37m (based on UHB estate department assessments and departmental funding requests etc).

A 2019 Estates Strategy targeted backlog reduction by 10% per annum. However, since that date, the reported total backlog has effectively doubled. At the time of the current review, there was no revised plan in place to fund the increased levels of backlog.

In the short to medium term, the Health Board has utilised a combination of all Wales capital funding, targeted EFAB funding, planned / reactive maintenance, and discretionary funding to address identified high priority areas. We raised a range of recommendations over the improvement of the baseline data and a review of the risk profile.

The Newport East audit.
The Nevill Hall Radiotherapy audit.

2.4.3 Approach to Follow Up of Recommendations

As part of our audit work, we consider the progress made in implementing the actions agreed from our previous reports for which we were able to give only Limited Assurance. In addition, where appropriate, we also consider progress made on high priority findings in reports where we were still able to give Reasonable Assurance. We also undertake some testing on the accuracy and effectiveness of the audit recommendation tracker.

In addition, Audit Committees monitor the progress in implementing recommendations (this is wider than just Internal Audit recommendations) through their own recommendation tracker processes. We attend all audit committee meetings and observe the quality and rigour around these processes.

2.4.4 Limitations to the Audit Opinion

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems.

As mentioned above the scope of the audit opinion is restricted to those areas which were the subject of audit review through the performance of the risk-based Internal Audit plan. In accordance with auditing standards, and with the agreement of senior management and the Board, Internal Audit work is deliberately prioritised according to risk and materiality. Accordingly, the Internal Audit work and reported outcomes will bias towards known weaknesses as a driver to improve governance risk management and control. This context is important in understanding the overall opinion and balancing that across the various assurances which feature in the Annual Governance Statement.

Caution should be exercised when making comparisons with prior years. Audit coverage will vary from year to year based upon risk assessment and cyclical coverage on key control systems. In addition, the impact of COVID-19 on last year's programme makes any comparison even more difficult.

2.4.5 Period covered by the Opinion

Internal Audit provides a continuous flow of assurance to the Board and, subject to the key financials and other mandated items being completed in-year, the cut-off point for annual reporting purposes can be set by agreement with management. To enable the Head of Internal Audit opinion

to be better aligned with the production of the Annual Governance Statement a pragmatic cut-off point has been applied to Internal Audit work in progress.

By previous agreement with the Health Board, audit work reported to draft stage has been included in the overall assessment, with all other work in progress rolled-forward and reported within the overall opinion for next year.

The majority of audit reviews will relate to the systems and processes in operation during 2023/24 unless otherwise stated and reflect the condition of internal controls pertaining at the point of audit assessment.

Follow-up work will provide an assessment of action taken by management on recommendations made in prior periods and will therefore provide a limited scope update on the current condition of control and a measure of direction of travel.

There are some specific assurance reviews which remain relevant to the reporting of the organisation's Annual Report required to be published after the year end. Where required, any specified assurance work would be aligned with the timeline for production of the Health Board's Annual Report and accordingly will be completed and reported to management and the Audit, Risk and Assurance Committee subsequent to this Head of Internal Audit Opinion. However, the Head of Internal Audit's assessment of arrangements in these areas would be legitimately informed by drawing on the assurance work completed as part of this current year's plan.

2.5 Required Work

Please note that following discussions with Welsh Government we were not mandated to audit any areas in 2023/24.

2.6 Statement of Conformance

The Welsh Government determined that the Public Sector Internal Audit Standards (PSIAS) would apply across the NHS in Wales from 2013/14.

The provision of professional quality Internal Audit is a fundamental aim of our service delivery methodology and compliance with PSIAS is central to our audit approach. Quality is controlled by the Head of Internal Audit on an ongoing basis and monitored by the Director of Audit & Assurance. The work of Internal Audit is also subject to an annual assessment by Audit Wales. In addition, at least once every five years, we are required to have an External Quality Assessment. This was undertaken by the Chartered Institute of Public Finance and Accountancy (CIPFA) in February and March 2023. CIPFA concluded that NWSSP's Audit & Assurance Services conforms with all 64 fundamental principles. It is therefore appropriate for NWSSP Audit & Assurance Services to say in reports and other literature that it conforms to the IIA's professional standards and to PSIAS.'

The NWSSP Audit and Assurance Services can assure the Audit, Risk and Assurance Committee that it has conducted its audit at the Health Board in conformance with the Public Sector Internal Audit Standards for 2023/24.

Our conformance statement for 2023/24 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2022/23 which will be reported formally in the Summer of 2023; and
- the results of the EQA undertaken by CIPFA in 2023.

We have set out, in **Appendix A**, the key requirements of the Public Sector Internal Audit Standards and our assessment of conformance against these requirements. The full results and actions from our QAIP will be included in the 2023/24 QAIP report. There are no significant matters arising that need to be reported in this document.

We also note that there have been no impairments to the independence of the Head of Internal Audit or to any other member of NWSSP's Audit & Assurance Service who undertook work on the Health Board's audit programme for 2023/24.

2.7 Completion of the Annual Governance Statement

While the overall Internal Audit opinion will inform the review of effectiveness for the Annual Governance Statement, the Accountable Officer and the Board need to take into account other assurances and risks when preparing their statement. These sources of assurances will have been identified within the Board's own performance management and assurance framework and will include, but are not limited to:

- direct assurances from management on the operation of internal controls through the upward chain of accountability;
- internally assessed performance against the Health & Care Standards;
- results of internal compliance functions including Local Counter-Fraud, and risk management;
- reported compliance via the Welsh Risk Pool regarding claims standards and other specialty specific standards reviewed during the period; and
- reviews completed by external regulation and inspection bodies including Audit Wales and Healthcare Inspectorate Wales.

3. OTHER WORK RELEVANT TO THE HEALTH BOARD

As our internal audit work covers all NHS Wales organisations there are a number of audits that we undertake each year which, while undertaken

formally as part of a particular health organisation's audit programme, will cover activities relating to other Health bodies. These are set out about below, with relevant comments and opinions attached, and relate to work at NHS Wales Shared Services Partnership.

NHS Wales Shared Services Partnership (NWSSP)

As part of the internal audit programme at NHS Wales Shared Services Partnership (NWSSP), a hosted body of Velindre University NHS Trust, a number of audits were undertaken which are relevant to the Health Board. These audits of the financial systems operated by NWSSP, processing transactions on behalf of the Health Board, derived the following opinion ratings:

Audit	Opinion	Outline Scope
Accounts Payable	Reasonable	The purpose of the audit review was to evaluate and determine the adequacy of the systems and controls in place for the NWSSP Accounts Payable service.
Primary Care (GMS)	Reasonable	The purpose of the audit review was to provide assurance that Primary Care Services is maintaining a robust system to facilitate timely and accurate payments to General Medical Services primary care contractors.
Payroll	Substantial	The overall objective of this audit was to evaluate the design and operation of the systems and controls in place within payroll services.
Procurement	TBC	To review the adequacy of the systems and controls in place for procurement of contracts above OJEU thresholds.

Please note that other audits of NWSSP activities are undertaken as part of the overall NWSSP internal audit programme. The overall Head of Internal Audit Opinion for NWSSP is Reasonable Assurance.

Digital Health & Care Wales (DHCW)

As part of the internal audit programme at DHCW, a Special Health Authority, a number of audits were undertaken which are relevant to the Health Board. These audits derived the following opinion ratings:

Audit	Opinion	Outline Scope
Benefits Realisation	Reasonable	To determine if the principles of an appropriate benefits realisation framework have been implemented to support decision making.
Programme Management	Reasonable	To provide an opinion of the project management being operated over the Digital Services for Patients and Public (DSPP) programme.
Business Continuity (Ransomware)	Reasonable	To assess the adequacy and effectiveness of business continuity arrangements, including in the event of a cyber-attack (including ransomware).
Legacy Software Modernisation	Reasonable	To review the management of risks associated with older technology.

Please note that other audits of DHCW activities are undertaken as part of the overall DHCW internal audit programme. The overall Head of Internal Audit Opinion for DHCW is Reasonable Assurance.

Welsh Health Specialised Services Committee (WHSSC) and Emergency Ambulance Services Committee (EASC)

The work at both the Welsh Health Specialist Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC) is undertaken as part of the Cwm Taf Morgannwg internal audit plan. These audits are listed below and derived the following opinion ratings:

Audit	Opinion	Outline Scope
WHSCC – Welsh kidney network	Substantial	To consider the governance arrangements in place for the Welsh Kidney Network following the independent governance review undertaken in 2022. We also aimed to provide assurance that there are

		robust and effective risk management arrangements in place that strengthen and contribute to the overall governance framework.
WHSSC – Integrated commissioning plan development process	Substantial	The overall purpose of the review was to provide assurance on the processes that WHSSC has in place to develop its Integrated Commissioning Plan, with a focus on the financial planning element.
EASC – Adult critical care transfer service	WIP	Our review focused on the governance arrangements, financial monitoring, meeting outcomes and performance monitoring, and the process to meeting longer term needs.

While these audits do not form part of the annual plan for the Health Board, they are listed here for completeness as they do impact on the organisation's activities. The Head of Internal Audit has considered if any issues raised in the audits could impact on the content of our annual report and concluded that there are no matters of this nature.

Full details of the NWSSP audits are included in the NWSSP Head of Internal Audit Opinion and Annual Report and are summarised in the Velindre NHS Trust Head of Internal Audit Opinion and Annual Report. DHCW audits are summarised in the DHCW Head of Internal Audit Opinion and Annual Report, and the WHSSC and EASC audits are summarised in the Cwm Taf Morgannwg University Health Board Head of Internal Audit Opinion and Annual Report.

4. DELIVERY OF THE INTERNAL AUDIT PLAN

4.1 Performance against the Audit Plan

The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Audit, Risk and Assurance Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Audit, Risk and Assurance Committee during the year. Audits that remain to be reported but are reflected within this Annual Report will be reported alongside audits from the 2023/24 operational audit plan.

The audit plan approved by the Committee in April 2023 contained 29 planned reviews. We undertook an additional review over an emerging risk with the audit of the Facilities Bank Approval Process. We also deferred three audits: The Health and Social Care (Quality and Engagement)(Wales)

Act; Job Planning; and Allegations against Staff Policy to a more appropriate time. These changes were reported to and approved by the Audit, Risk and Assurance Committee. As a result of these agreed changes we have delivered 27 reviews, plus three capital audits completed as part of the integrated audit plan.

The assignment status summary is reported at Section 5.

In addition, we may respond to requests for advice and/or assistance across a variety of business areas across the Health Board. This advisory work, undertaken in addition to the assurance plan, is permitted under the standards to assist management in improving governance, risk management and control. This activity is reported during the year within our progress reports to the Audit, Risk and Assurance Committee.

4.2 Service Performance Indicators

In order to monitor aspects of the service delivered by Internal Audit, a range of service performance indicators have been developed. These are reported quarterly.

Indicator Reported to NWSSP Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2023/24	G	April 2023	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2023/24	G	100%	100%	v>20%	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	G	76%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100%	80%	v>20%	10%<v<20%	v<10%

5. RISK BASED AUDIT ASSIGNMENTS

The overall opinion provided in Section 1 and our conclusions on individual assurance domains is limited to the scope and objectives of the reviews we have undertaken, detailed information on which has been provided within the individual audit reports.

5.1 Overall summary of results

In total 32 reviews were reported during the year. Figure 2 below presents the assurance ratings and the number of audits derived for each.

Figure 2 Summary of audit ratings

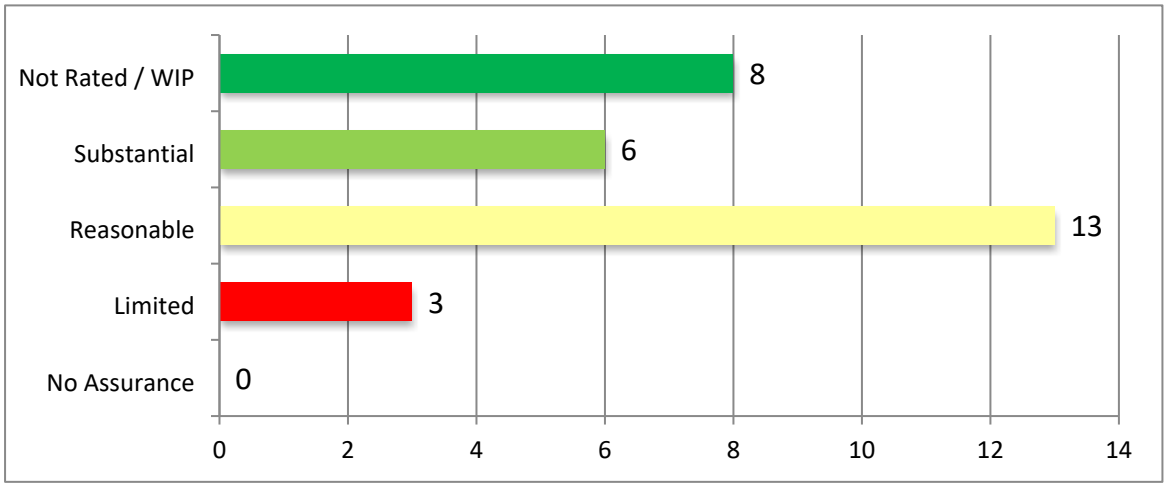


Figure 2 above does not include the audit ratings for the reviews undertaken at NWSSP.

The assurance ratings and definitions used for reporting audit assignments are included in **Appendix B**.

The following sections provide a summary of the scope and objective for each assignment undertaken within the year along with the assurance rating.

5.2 Substantial Assurance (Green)



In the following review areas the Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Those few matters that may require attention are compliance or advisory in nature with low impact on residual risk exposure.

Review Title	Objective
Financial Controls	The overall objective of the audit was to assess the controls in place to ensure appropriate financial reporting.
Integrated Performance Dashboard – Data Quality	The overall objective of the audit was to assess the accuracy of data utilised within

Review Title	Objective
	the Integrated Performance Report (IPR) dashboard.
Early Supported Discharge – Stroke	The overall objective of the audit is to assess whether the arrangements in place for the early supported discharge of stroke patients are operating effectively.
Maternity Services – Action Plan	The internal audit reviewed the governance arrangements in place within Maternity Services, to ensure performance is being monitored effectively and risks managed appropriately.
Stakeholder Engagement on IT Projects	To review the framework in place for stakeholder engagement on key IT projects.
IAP: YYF Breast Care Services	The audit sought to review the management arrangements in place to progress the Ysbyty Ystrad Fawr Unified Breast Unit – in the period after the prior audit which was completed in December 2022.

5.3 Reasonable Assurance (Yellow)



In the following review areas the Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Some matters require management attention in either control design or operational compliance and these will have low to moderate impact on residual risk exposure until resolved.

Review Title	Objective
Asset Management	To assess the implementation of the electronic tagging and tracking of financial assets across the Health Board.
Medical Equipment and Devices	To assess the implementation of the electronic tagging and tracking of medical

Review Title	Objective
	equipment and devices across the Health Board.
Risk Management and Assurance	To assess the effectiveness of the risk management and assurance arrangements in place within the Health Board, in order to ensure that strategic objectives are achieved.
Integrated Medium Term Plan	To assess the controls to ensure the delivery of the IMTP / strategic objectives.
Business Continuity Planning	An audit of the arrangements that the Health Board has in place to maintain business continuity in the event of a major incident, including how learnings from the Covid-19 pandemic have been considered.
Safeguarding	To review the arrangements in place to ensure that the Health Board discharged its statutory responsibilities.
Waiting List Management	To establish whether all patients on the waiting list have been assessed and assigned an appropriate priority rating in line with the Royal College of Surgeons guidance, including the arrangements in place to communicate and support patients.
Directorate Review - Theatres	To undertake an audit of compliance with key policies and procedures and the management of risk within the Theatres directorate.
Clinical Coding	To determine if appropriate controls were in place for the timely recording of Finished Consultant Episodes, in accordance with clinical coding standards.
Intra-site Patient Transfers	To assess if the arrangements in place were appropriate for the transfer of patients between sites within the Health Board.
Long Term Sickness Absence Management	To review the compliance with policy, and assess mechanisms in place to provide assurance that the Health Board is acting promptly, managing the interests of all

Review Title	Objective
	parties and working in accordance with the wider wellbeing strategy.
Network Infrastructure (VPN)	To ensure that all risks associated with the provision of virtual protocol networks (VPNs) were appropriately mitigated.
LINC Programme	An audit of the arrangements in place to for the mitigation of risk associated with the non or late delivery of the LINC programme of work.

5.4 Limited Assurance (Amber)



In the following review areas, the Board can take only **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.

Review Title	Objective
Bevan Health and Wellbeing Centre	The audit sought to review the delivery and management arrangements in place to progress the Bevan Health & Wellbeing Centre.
Estates Assurance – Estates Condition	The audit sought to evaluate the arrangements put in place by the UHB to identify and manage key risks associated with the existing estate and the implementation of resulting strategies to manage/mitigate the risk.
Facilities Bank Approval Process	To provide assurance over whether appropriate stock processes were in place and whether applicable controls within the process for allocating / approving bank shifts were effective.

5.5 Unsatisfactory Assurance (Red)



No reviews were assigned a 'no assurance' opinion.

5.6 Assurance Not Applicable / Work in Progress (Grey)



The following reviews were undertaken as part of the audit plan and reported without the standard assurance rating indicator, owing to the nature of the audit approach. The level of assurance given for these reviews are deemed not applicable – these are reviews and other assistance to management, provided as part of the audit plan, to which the assurance definitions are not appropriate but which are relevant to the evidence base upon which the overall opinion is formed.

Review Title	Objective
Follow-up of High Priority Recommendations	To assess whether high priority internal audit recommendations had been implemented.
Flexible Working	An advisory review to determine if the requirements of the Flexible Working Policy and Guidance were being applied consistently across the organisation.
Savings Programmes	To provide assurance that the savings programmes are specific, realistic and measurable and that monitoring arrangements are effective.
Providing Care to Asylum Seekers	To provide an opinion over the arrangements in place for providing care to asylum seekers and refugees and applicable guidance is being adhered to (e.g. Policy Implementation Guidance: Health and wellbeing provision for refugees and asylum seekers, issued by the Welsh Government).
ABUHB Financial Controls - Regional Partnership Board	The overall aim of this audit was to ensure that the Health Board's Budgetary Control

Review Title	Objective
	Financial Control Procedure (the 'FCP') is adhered to when local actions / financial transactions, in relation to the Regional Partnership Board, are processed internally.
IAP: Newport East	TBC
IAP: Nevill Hall Radiotherapy	TBC
Decarbonisation	To consider progress against the NHS Wales Decarbonisation Strategic Delivery Plan. Following on from the advisory review delivered in 2022/23, the proposed scope included governance, strategy progress and implementation.

5.7 Draft Audit Reports

The following audits have been substantially completed, with the draft reports issued. Therefore, the conclusions of our audit work have been taken into account for the 2023/24 Head of Internal Audit Opinion. Overall, there is no adverse impact on the Opinion.

Review Title

5.8 Deferred Audits

There were three deferred audits this year, including The Health and Social Care (Quality & Engagement) (Wales) Act; Job Planning; and Allegations against Staff Policy. In each case, agreement with the Audit, Risk and Assurance Committee was obtained prior to the deferral. This was carefully considered and there has been no impact on the Opinion.

6. ACKNOWLEDGEMENT

In closing I would like to acknowledge the time and co-operation given by Directors and staff of the organisation to support delivery of the Internal Audit assignments undertaken within the 2023/24 plan.

Stephen Chaney
Actio Pennaeth yr Archwiliad Mewnol/Acting Head of Internal Audit
Gwasanaethau Archwilio a Sicrwydd/Audit and Assurance Services
Partneriaeth Cydwasanaethau GIG Cymru/NHS Wales Shared Services Partnership
May 2024

Appendix A

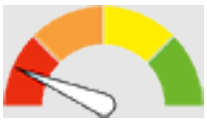
ATTRIBUTE STANDARDS	
1000 Purpose, authority and responsibility	Internal Audit arrangements are derived ultimately from the NHS organisation's Standing orders and Financial Instructions. These arrangements are embodied in the Internal Audit Charter adopted by the Audit, Risk and Assurance Committee on an annual basis.
1100 Independence and objectivity	Appropriate structures and reporting arrangements are in place. Internal Audit does not have any management responsibilities. Internal audit staff are required to declare any conflicts of interests. The Head of Internal Audit has direct access to the Chief Executive and Audit, Risk and Assurance Committee chair. There have been no impairments to our independence during 2022/23.
1200 Proficiency and due professional care	Staff are aware of the Public Sector Internal Audit Standards and code of ethics. Appropriate staff are allocated to assignments based on knowledge and experience. Training and Development exist for all staff. The Head of Internal Audit is professionally qualified.
1300 Quality assurance and improvement programme	Head of Internal Audit undertakes quality reviews of assignments and reports as set out in internal procedures. Internal quality monitoring against standards is performed by the Head of Internal Audit and Director of Audit & Assurance. An EQA was undertaken in 2018.
PERFORMANCE STANDARDS	
2000 Managing the internal audit activity	The Internal Audit activity is managed through the NHS Wales Shared Services Partnership. The audit service delivery plan forms part of the NWSSP integrated medium term plan. A risk based strategic and annual operational plan is developed for the organisation.

	The operational plan gives detail of specific assignments and sets out overall resource requirement. The audit strategy and annual plan is approved by Audit, Risk and Assurance Committee. Policies and procedures which guide the Internal Audit activity are set out in an Audit Quality Manual. There is structured liaison with Audit Wales, HIW and LCFS.
2100 Nature of work	The risk based plan is developed and assignments performed in a way that allows for evaluation and improvement of governance, risk management and control processes, using a systematic and disciplined approach.
2200 Engagement planning	The Audit Quality Manual guides the planning of audit assignments which include the agreement of an audit brief with management covering scope, objectives, timing and resource allocation.
2300 Performing the engagement	The Audit Quality Manual guides the performance of each audit assignment and report is quality reviewed before issue.
2400 Communicating results	Assignment reports are issued at draft and final stages. The report includes the assignment scope, objectives, conclusions and improvement actions agreed with management. An audit progress report is presented at each meeting of the Audit, Risk and Assurance Committee. An annual report and opinion is produced for the Audit, Risk and Assurance Committee giving assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.
2500 Monitoring progress	An internal follow-up process is maintained by management to monitor progress with implementation of agreed management actions. This is reported

	to the Audit, Risk and Assurance Committee. In addition audit reports are followed-up by Internal Audit on a selective basis as part of the operational plan.
2600 Communicating the acceptance of risks	If Internal Audit considers that a level of inappropriate risk is being accepted by management it would be discussed and will be escalated to Board level for resolution.

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.
	**Unsatisfactory 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.

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Bevan Health & Wellbeing Centre

Final Internal Audit Report

April 2024

Aneurin Bevan University Health Board

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

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

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Auditors:	NWSSP Audit & Assurance: Specialist Services Unit
Executive sign-off:	Tracy Daszkiewicz, Executive Director of Public Health (Senior Responsible Officer)
Distribution:	Hannah Evans – Executive Director of Strategy Planning & Partnerships Hannah Capel - Associate Director Strategic Capital Lorraine Morgan - Project Manager Kelly Jones – Head of Capital Finance Rani Dash, Director of Corporate Governance
Committee:	Audit Committee

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

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

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

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

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

Executive Summary

Purpose

The audit sought to review the delivery and management arrangements in place to progress the Bevan Health & Wellbeing Centre.

Overall Audit Opinion and Overview

Limited assurance has been determined at this review.

This assessment primarily recognises the significant delays to the delivery of the project (currently circa 49.6 weeks) which are attributed to the Supply Chain Partner (SCP). There will therefore be a corresponding delay in achieving the anticipated business case objectives.

The project was also forecast to be £828k (4.2%) over the approved budget, **£478k** of which had already been funded from the discretionary capital programme for 2023/24 with the remaining overspend to be funded from the University Health Board's (UHB) 2024/25 discretionary capital allocation.

At the time of the review, discussions were ongoing with Welsh Government (WG) regarding extra funding – particularly as a significant element of cost increase was associated with unfunded inflationary uplifts.

The SCP delays outlined above have allowed the UHB to apply and continue to apply damages for the period from expected completion to the revised completion date.

The SCP is disputing the attestation of culpability for the delays with the associated costs estimated to range between £2.58 and £4.51m. Welsh Government has been fully briefed and the UHB has engaged legal advice on the matter.

The project faces significant challenges going forward as the contractor is likely to be operating at a loss – accordingly, maintaining reasonable performance from the SCP through existing project management tools will be essential through to completion and handover

Report Classification

		Trend
Limited 	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved	2022/23 

Assurance Summary [1]

Assurance objectives		Assurance
1	Project Performance	Limited
2	Validation of Management Action	Reasonable
3	Project Management	Reasonable
4	Site Records	Substantial
5	Change Management	Substantial
6	Performance	Reasonable
7	Risk Management	Limited

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

Key Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
1.1	The Project was in an overspend position with further costs anticipated in respect of unfunded cost increases and potential delay compensation.	*1*	Operation	**High**
2.1	The Project Board should meet on a monthly basis.	*3*	Operation	**Medium**
3.1	Formal KPI monitoring for the Supervisor appointment should be considered.	*4*	Design	**Medium**
3.3	The Project Board should have an opportunity to review/discuss KPI returns in advance of their submission to WG	*6*	Operation	**Medium**
4.1	The UHB should adopt more robust mechanisms to manage ongoing issues of poor performance and service delivery from suppliers.	*6*	Design	**Medium**
5.1	Risk registers should include risk costs, risk owners (named individuals), and time parameters for risk mitigations.	*7*	Operation	**Medium**
5.2	The estimated contingency requirement should be periodically updated in the Project Risk register.	*7*	Operation	**Medium**

1. Introduction

1.1 The audit reviewed the delivery and the management arrangements in place to progress the Bevan Health & Wellbeing Centre (formerly referred to as the Tredegar Health & Wellbeing Centre). This audit was commissioned in accordance with the agreed audit plan (and associated fee) provided within the approved Full Business Case (FBC) for the project.

1.2 The Welsh Government (WG) approved the FBC on 18th March 2021 with an associated capital cost of £19.488m. The main works contract specified commencement on 4th May 2021, with completion due on 22nd August 2023 (120 weeks).

1.3 The potential risks considered in the review were as follows:

- The failure to achieve key project objectives through poor governance and project management controls;
- The Health Board may be in breach of Welsh Government funding stipulations, Standing Orders or Standing Financial Instructions;
- The target cost may not provide sufficient value for money; and
- Project costs may escalate uncontrollably through an absence of adequate cost monitoring and reporting

2. Detailed Audit Findings

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

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

2.2 At this stage of the Bevan Health & Wellbeing project, when assessing progress against the original delivery objectives, this audit notes that:

Time

2.3 The project time performance is summarised below:

	Business Case	**Contract**	**Revised Contract**	**SCP current programme** (M05.02)
Commencement	May 2021	4th May 2021	4th May 2021	4th May 2021
Completion	April 2023	22nd August 2023	11th September 2023	28th August 2024

2.4 The overall contract completion date was revised to the 11th of September 2023, following an agreed extension to the original programme of twenty days.

2.5 After this date, the UHB had applied liquidated and ascertained damages of £2,121 per day, in accordance with clauses X7 and X7.3 of the contract with the Supply Chain Partner (SCP).

2.6 Whilst the contract did not include sectional completion, the project consisted of two phases. The first being the delivery of the Bevan Wellbeing and Health Centre which at the time of the review was due to be handed over to the UHB on the 18th of December 2023. At this juncture, to recognise partial possession, the damages to be applied will reduce to £666.67 per day, in accordance with clauses X7 and X7.3 of the contract.

2.7 The second phase of the contract includes some demolition work and the provision of car park facilities which was anticipated to complete on the 28th of August 2024 (as per the SCP's latest programme (M12) – an overall delay of 49.6 weeks).

2.8 At the time of the review, the UHB had reported that the SCP had invoked the contractual disputes resolution process to challenge the assessment of culpable delay. In response, the UHB had appointed a firm of solicitors to provide legal advice to support the UHB's position.

Cost

2.9 The forecast out-turn cost position, as summarised at the October 2023 Commercial Cost Report (No58), was:

Costs	WG Approvals £m	Forecast Outturn £m
Works	12,753,520	13,713,797
Fees	2,078,699	2,353,211
Non-works	845,436	1,050,318
Equipment	189,585	189,585
Contingency	643,675	-
VAT (incl. reclaim)	2,977,057	3,009,827
Total	**19,488,000**	**20,316,738**
Anticipated (over) / underspend		**(828,738)**

2.10 The costs as detailed in the table above, include unfunded costs (related to inflation allowances on works and fees, electric vehicle (EV) charging and other required changes).

2.11 The UHB reported that a meeting took place with NWSSP Specialist Estates Services (SES) to discuss the unfunded costs; the figure at the time a reported £1.137m (ex VAT). The UHB are to submit a funding request to WG for the funds to cover this.

2.12 Should WG approve this funding, this would then change the relative outturn position for the project into a more favourable position. However, should this additional funding not be approved, this will present a financial risk to the UHB.

2.13 The Strategic Capital Projects and Estate Rationalisation report dated 1st November 2023 and presented at the UHB's Partnerships; Population Health & Planning Committee notes this risk detailing that:

'Discussions are ongoing with WG regarding the funding of this cost pressure. If WG do not support the additional funding, this will be a financial risk to the Health Board'.

2.14 It was noted that further risks were identified in relation to five unresolved compensation events which have been assessed by the UHB's Cost Advisers as potentially totalling between £2.589m and £4.151m, which were not built into the forecast outturn and had been challenged by the SCP. If these claims were later found to be valid, they would significantly increase the reported overspend position and further add to the overall financial risk to the UHB. (**MA1.1**)

2.15 **Quality**

2.16 The original investment objectives (included within the business case) were to:

- Support the co-location and potential merger of General Practitioner (GP) Practices within Tredegar;
- Support the increased provision and improved integration of Health and Well-Being Services within Tredegar;
- Address the significant estate infrastructure issues that exist at the Tredegar Hospital site; and
- Support the effective use of clinical and non-clinical resources that were delivered within Tredegar.

2.17 While there were delays to intended enhancements to service provision and the estate, existing services continue to be provided elsewhere.

2.18 Recognising the current stage of construction, **limited assurance** has been determined in respect of project performance. This assessment primarily acknowledges the significant delays in the delivery of the project, the associated current cost pressures, and the delay in achieving anticipated business case objectives.

2.19 The following sections of the report further outline the key observations that have contributed to the above – matters which require management attention, with moderate impact on residual risk exposure until resolved.

Validation of Management Action: *to confirm that previously agreed recommendations have been appropriately actioned by management.*

2.20 The table below provides an overview of progress in implementing the previously agreed management actions in relation to the 2022/23 audit report (published in March 2023).

Original Priority Rating	Number of Recommendations	Implemented	Not implemented	Closed / superseded
High	2	1	-	1
Medium	9	8	1	-
Low	3	1	2	-
Total	**14**	**10**	**3**	**1**

2.21 Recommendations requiring further action are detailed at **Appendix B.** The key outstanding/ superseded recommendations related to:

- Risk monitoring (high priority) – This issue has been re-raised at the current review, as arrangements required improvement to include quantified total of mitigated risks reported against remaining contingency, risk costs, risk owners (named individuals), and time parameters for risk mitigations at risk registers.
- Leases (medium priority) - Management should obtain signed lease agreements with relevant parties at the earliest opportunity.

2.22 Recognising the actions taken, **reasonable assurance** has been determined in relation to previously agreed actions.

Project Management: *assurance that effective arrangements were in place to administer and manage the project, including change management, risk management and programme management.*

2.23 Project governance arrangements were defined at the Programme Execution Plan (PEP) which included the programme objectives, structures, and key roles. The PEP had been reviewed/ revised in September 2023.

2.24 A new Senior Responsible Officer (SRO) was appointed at the Project in August 2023.

2.25 Up to April 2023, oversight had been provided by the Primary Care & Community Estates Programme Board ('the Programme Board'), with onward reporting to the Strategic Capital & Estates Programme workstream.

2.26 There was however a hiatus in April 2023 with no further Programme Board meetings held.

2.27 The UHB clarified that a decision had been made to establish a dedicated Project Board in response to the findings of a project governance recommendation made in earlier audit reports regarding the review of this scheme and another ABUHB project.

2.28 There was an absence of project oversight then until August 2023, when the newly formed Project Board met for the first time with a second meeting in October 2023.

2.29 Regular Project Board Meetings are an essential aspect of robust project governance. The delay in replacing the Programme Board with the Project Board denied the scheme appropriate scrutiny at a key stage of the scheme particularly

noting the adverse time and cost pressures being experienced at the project. (**MA2.1**)

2.30 The Project Board was chaired by the SRO, and membership included the Strategic and Capital Project Director, Capital Programme Manager, Head of Primary Care and Divisional Director of Primary Care and Community Services (Vice Chair).

2.31 The Project Board was supported by a Project Team, the membership of which included the Strategic and Capital Project Director, Capital Programme Manager, Capital Finance Lead, estates personnel, and user representation.

2.32 A review of the minutes for a sample of Project Board and Project Team meetings, confirmed that they had been well attended, being quorate with the minutes reflecting a good level of discourse around the agenda items presented.

2.33 Subsequent to the audit fieldwork, it was evident that monthly Project Board meetings had been reinitiated (addressing the absence of Project Board oversight during a period of 2023). Recognising the same, **Reasonable Assurance** has therefore currently been determined in relation to governance arrangements applied at the project.

Site records: *assurance that appropriate site inspections and records were maintained in accordance with the contract.*

2.34 The Supervisor team had access to site records (drawings, programme etc.) via A-Site (a construction document management system).

2.35 The Supervisor provided weekly progress & activity reports. The reports were found to be comprehensive in nature and shared with the UHB in a timely manner.

2.36 Noting the Supervisor appointment was not made from the NHS Building for Wales Framework, the associated 6-monthly key performance indicators (KPIs) had not been mandated. Whilst management confirmed they had no concerns over Supervisor performance to date, with delivery of duties and quality of output monitored against the Schedule of Services contained within the Contract, the addition of formal performance metrics would enhance this process. **(MA3.1)**

2.37 Good practice was evidenced in relation to site inspections and reporting, accordingly **substantial assurance** has therefore been determined.

Change Management: *assurance that changes were processed / authorised in accordance with the contract and local internal control procedures.*

2.38 The change management process (Compensation Event / Early Warning Notice) was detailed within the National Engineering Contract 3 (NEC3) adopted.

2.39 The Health Board's own Capital Project Change Management Procedure was included as an appendix within the latest version of the PEP (v3 21st September 2023).

2.40 A sample of project changes showed appropriate completion of Health Board change control forms, and detailed analysis and support, as reviewed by the Project Manager. It was evident that compensation events were subject to challenge by the Project Manager in accordance with the NEC contract. Similarly

good practice was observed in the maintenance of a Change Control Tracker by the external Project Manager. A copy of which was included within the monthly Project Manager's Progress Report.

2.41 The latest project Highlight report as prepared for the November 2023 Project Team meeting, recorded that 127 Compensation Events had been issued by the SCP since the beginning of stage 4, of which 3 remain to be implemented. With a further 1 awaiting quotation.

2.42 Noting the above, **substantial** assurance has currently determined in relation to change management.

Performance: *assurance that appropriate arrangements were in place to performance manage the internal team, external advisers (including the role of the Supervisor), and the main contractor – identifying appropriate corrective action to address performance.*

2.43 The NHS Building for Wales framework requires 6-monthly KPIs to be submitted by all parties.

2.44 The UHB had submitted KPIs to NWSSP: SES in accordance with the requirements of the framework. However, it was noted that the submissions were made a month after the deadline set by NWSSP: SES. **(MA3.2)**

2.45 It was also observed that whilst the KPI's for October 2023 were shared with the Project Team meeting prior to submission, the Project Board were not sighted until the November 2023 meeting. **(MA3.3)**

2.46 The KPIs as completed show that the overall performance of both the SCP and advisers had been assessed by the Project Director as having only improved slightly over the six-month period covered by the two submissions reviewed.

2.47 In the case of the PM Adviser role the scores as assessed remain within the classification – 'neutral tending towards satisfaction', with timely delivery of services/information being a particular concern, and with no improvement evident over time from the scores as submitted. **(MA4.1)**

2.48 Noting the above, **reasonable** assurance has currently been determined in relation to performance management.

Risk Management: *assurance that appropriate arrangements were in place to oversee the management of project risks, including the action taken by management to mitigate/ manage key risks.*

2.49 The UHB maintained two risk registers in respect of the project:

- Capital Cost Risk Register – the register was provided within the Project Manager's reports and additionally included within Highlight reports.
- Opening risk register – this operational risk register was focused on internal UHB risks that were not related to the build itself. Examples being revenue implications and future risks to service delivery.

2.50 Good practice was noted in that the Capital Cost Risk Register

as maintained had been:

- routinely updated, and contained details of potential risks arising from Early Warning Notices, these reconciled back to those detailed within the Project Manager's Progress report and were detailed in PPR returns to Welsh Government.
- The Capital Cost Risk register split risk ownership between either client or SCP risks.
- It was given due prominence, being published within the monthly Project Manager's reports, that the Project Board members were sighted on ahead of Project Board meetings.

2.51 However it was noted that the potential values of Compensation Event claims, and Early Warning Notices (best, worst, and likely case scenarios) had not been included within the risk register as required by NEC guidance. (**MA5.1**)

2.52 This assessment of values of Early Warning Notices was included in the stage 4 commercial report prepared by the UHB's Cost Advisers. This was detailed as representing forecast outturn scenario planning and included an estimate of potential future claims by the SCP.

2.53 The copy of the Capital Cost Risk Register (main scheme) as included as part of the bi-monthly PPR returns for September 2023 identified total quantified risks of £151k.

2.54 In addition, the quantification of costs driven by risk was included in the UHB's month 6 summary capital plan which details unfunded costs of £1.137m ex vat and further risks in relation to five unresolved compensation events totalling £1,960m ex vat. **(MA5.2)**

2.55 Whilst noting the form, updates and availability of the project risk register, the copy as presented at Project Board and Team meetings remained uncosted. Similarly, the version included within PPR returns included a quantification of cost yet excluded those pertaining to unfunded costs and potential delay claims. Acknowledging the above, **limited** assurance has currently determined in relation to risk management.

Appendix A: Management Action Plan

Matter Arising 1: Project budget cost risks - frequency (Operation)	**Impact**
The Bevan Health and Well-being Centre scheme was forecasting an overspend of £0.828m which was being funded by the Discretionary Capital Programme (DCP) across the 23/24 and 24/25 financial years. The above includes £1.137m ex VAT of unfunded costs in relation to inflation allowances on works and fees. The UHB had been engaged in discussions with WG to try to secure extra funding which would meet these costs, if realised this would alter the complexion of the current forecast budget position. The project contingency of £658k had been fully utilised and as noted the shortfall in funding was to be met from discretionary capital. Further costs could be incurred, the UHB's Month 7 2023/24 Summary Capital Plan (Board Report) noted that any additional costs accepted as part of the most recent delays will increase the overspend that was being funded by DCP. With the UHB (along with all other UHB/Trusts in Wales) having a reduced allocation of discretionary capital funding and needing to meet increasing competing demands with finite resources, the need to divert funds to meet Project shortfalls presents a significant financial risk to the UHB. ***Note:*** *The above does not account for five unresolved compensation events which total £2.006m plus VAT which are currently being disputed by the SCP.*	Potential risk of: • Project Cost exceeding agreed cost envelope.
Recommendations	**Priority**
1.1 The UHB should formally clarify how it intends to meet the potential funding shortfalls, including any associated impact on the UHBs discretionary capital programme and investment priorities (reporting the same to the Project Board and Board as appropriate).	**High**

Agreed Management Action	Target Date	Responsible Officer
Actioned - A paper was prepared and presented at the Executive Team Meeting held on the 11th April with further inclusion at the In-Committee Board Meeting held on the 16th April. The paper which is commercially sensitive details the not to exceed value in respect of the claim arising through the NEC Contract disputes process, and the UHB's process through which the financial risk will be mitigated, primarily being managed through the Health Board Discretionary Capital Programme.	Actioned – the UHB has formally clarified how it intends to meet the potential funding shortfalls, including any associated impact on the UHBs discretionary capital programme and investment priorities	Executive Director of Planning, Partnerships and Strategy

Matter Arising 2: Project Board Meetings - frequency (Operation)		**Impact**
Up until April 2023, oversight had been provided by the Primary Care & Community Estates Programme Board ('the Programme Board'), with onward reporting to the Strategic Capital & Estates Programme workstream. A dedicated Project Board was then established, this first met in August 2023, with its second meeting taking place in October 2023. There was a period of four months between the last meeting of the Programme Board meeting and the first Project Board meeting taking place. The UHB attributed this delay in transitioning to a dedicated Project Board to internal resource/timing difficulties. Regular Project Board Meetings are an essential aspect of robust project governance. The delay in replacing the Programme Board with the Project Board denied the scheme appropriate scrutiny at a key stage of the scheme particularly noting the adverse time and cost pressures being experienced at the project.		Potential risk of: • The Project lacks appropriate and timely scrutiny of progress against the key measures of time, quality, and cost.
Recommendations		**Priority**
2.1 The Project Board should meet in line with the frequency set out in the Project Execution Plan. To ensure continuing robust governance and oversight of the project.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
Actioned –Subsequent to the completion of the audit fieldwork, the reconstituted Project Board have met monthly.	N/A Actioned since audit fieldwork	N/A Actioned since audit fieldwork

Matter Arising 3: Site records – monitoring and reporting (Design)	**Impact**
The NHS Building for Wales Framework does not provide for Supervisor services, therefore the associated framework KPIs are not mandated for the role. Management noted that performance was monitored locally. However, formal record of this assessment was not maintained or reported. Whilst acknowledging that no concerns had been noted regarding Supervisor performance to date, formal performance monitoring (aligned to the NHS Building for Wales process but recognising this will have to be managed separately) would be good practice, recognising the financial value and importance of this appointment. The UHB had made six monthly returns of Key Performance Indicators (KPIs) to NWSSP: SES in accordance with the NHS Building for Wales Framework requirements for the SCP and remaining adviser appointments. However, it was noted that the submissions were made a month after the deadline dates set by NWSSP: SES. It was also observed that whilst the KPI's for October 2023 were shared with the Project Team meeting prior to submission, the Project Board were not sighted until the November 2023 meeting. Therefore, the Project Board were not afforded the opportunity to discuss the scores as assessed and the rationale behind them prior to submission.	Potential risk of: • Inadequate performance may not be appropriately recorded, reported, and addressed. • Failing to meet obligations in respect of reporting to SES. • Project Board are not made aware of the determined KPIs ahead of their submission.

Recommendations	**Priority**
3.1 Formal KPI monitoring for the Supervisor appointment should be considered.	**Medium**
3.2 KPI returns should be submitted in a timely manner in keeping with SES timescales	**Low**
3.3 The Project Board should have an opportunity to review/discuss KPI returns in advance of their submission to WG	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**

3.1 Noted – given the amount of works remaining and simplistic nature of the work this will be addressed in future projects.	Future Projects	Assistant Director of Strategic Capital
3.2 Noted – given the amount of works remaining and simplistic nature of the work this will be addressed in future projects.	Future Projects	Assistant Director of Strategic Capital
3.3 Noted – given the amount of works remaining and simplistic nature of the work this will be addressed in future projects.	Future Projects	Assistant Director of Strategic Capital

Matter Arising 4: Performance – monitoring of adviser performance (Operation)		**Impact**
The KPIs completed show that the overall performance of both the SCP and advisers had been assessed by the Project Director as having been positive and having improved slightly over the six-month period covered by the two submissions reviewed. However, a more detailed review of the scores identified that, in the case of the Project Manager role, the scores as assessed remain within the classification – 'neutral tending towards satisfaction', with timely delivery of services/information being a particular concern, and with no improvement evident over time from the scores as submitted. From a review of the project documents and reports, it was not clear what corrective action had been agreed.		Potential risk of: • Inadequate performance may not be appropriately recorded, reported, and addressed.
Recommendations		**Priority**
4.1. The UHB should adopt more robust mechanisms to manage ongoing issues of poor performance and service delivery from suppliers. This should include the formal agreement of corrective action to address the identified shortfalls in performance.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
Noted – given the amount of works remaining and simplistic nature of the work this will be addressed in future projects.	Future Projects	Assistant Director Strategic Capital

Matter Arising 5: Risk register	Impact
The NHS Wales Infrastructure Investment Guidance states: *"Risk registers…. must be completed, shared, and monitored, with reference not only to time, cost, and quality but also operational/service impacts, functionality, and benefits realisation"* Management provided two risk registers for review: • Opening risk register – this version contained generic operational risks. It was un-costed and was for management the Project Team to track mitigating actions for assigned risk owners. • Capital Cost Risk Register – this was provided within Project Highlight reports and Project Manager reports, distinguishing between client and SCP risks, but not further identifying risk owners or action dates. While it contained some costs, these were not totalled to enable comparison of remaining client risk with Health Board contingency. A copy of the Capital Cost Risk Register was included within the PPR returns to WG, this included some costs but did not incorporate wider financial risk presented by unfunded costs and potential compensation claims from the SCP	Potential risk of: • Risks are not quantified, and contingent plans were not included demonstrating how risks will be mitigated.
Recommendations	**Priority**
5.1 Risk registers should include risk costs, risk owners (named individuals), and time parameters for risk mitigations.	**Medium**
5.2 As the project progresses, and requirements become firmer, so the risks in future works and commitments would be reduced. The estimated contingency requirement should be periodically updated to reflect this.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
5.1 Agree – given the amount of works remaining and simplistic nature of the work this will be addressed in future projects to include the risk costs, risk owners (named individuals), and time parameters for risk mitigations as recommended	Future Projects	Assistant Director Strategic Capital
5.2 Agree – given the amount of works remaining and simplistic nature of the work this will be undertaken as part of future risk reviews and updated accordingly	Future Projects	Assistant Director Strategic Capital

Appendix B: Status of previously agreed recommendations (2022/23)

Bevan Health & Wellbeing Centre (March 2023)			Previously providing 		
Ref	**Area**	**Previously agreed Action**	**Current Status**	**Revised Responsibility & Timescale**	**Priority Rating**
1.1	Governance- Project groups	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.	Implemented A dedicated Project Board had an inaugural meeting in August 2023 with Terms of Reference presented at the same meeting.	Director of Primary Care, Community and Mental Health services. June 2023	**Medium**
1.2	Governance – Project groups	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.	Implemented Monthly Project Board Meetings established in August 2023 with monthly meetings commencing in October 2023.	Director of Primary Care, Community and Mental Health services. June 2023	**Medium**
2.1	Governance- Roles and responsibilities	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.	Implemented A new SRO had been in post since August 2023 and a revised PEP updated July 2023 detailed the roles and responsibilities. Further revision of PEP in September 2023 adds details around authorisation	Project Director June 2023	**Medium**

Bevan Health & Wellbeing Centre (March 2023)			Previously providing 		
Ref	**Area**	**Previously agreed Action**	**Current Status**	**Revised Responsibility & Timescale**	**Priority Rating**
			of changes and links to Standing orders/SFIs		
2.2	Governance-Roles and responsibilities	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	Implemented The PEP was revised in July 2023.	Project Director June 2023	**Medium**
3	Governance-Risk management	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	Not Implemented - superseded Review of Capital and Service Risk Registers for period August – October 2023 do not reflect the completion of the Management action.	Project Director June 2023	**High**

Bevan Health & Wellbeing Centre (March 2023)			Previously providing 		
Ref	**Area**	**Previously agreed Action**	**Current Status**	**Revised Responsibility & Timescale**	**Priority Rating**
		numbering / referencing of common risks at project management, and contractual versions of the register.			
4	Governance-User agreements	Management should obtain signed lease agreements with relevant parties at the earliest opportunity.	Ongoing However, at time of audit, evidence was provided to demonstrate that efforts were being made to finalise the lease agreements.	Project Director June 2023	**Medium**
5.1	Governance-Cost reporting	Management should review the Project Progress Return submissions to Welsh Government to ensure accuracy.	Implemented PPR was included as an agenda item at the Project Team Meeting held on 23rd October 2023.	Project Director 30th June 2023	**Medium**
5.2	Governance- Cost reporting	The current cost reports should be reviewed by the UHB and the Cost Adviser and enhanced to improve clarity to afford greater scrutiny by the Programme Board and UHB officers.	Implemented Cost reports from the UHB's Cost Adviser have been revised and in addition the Cost Adviser now provides an additional section no 11. This section is sent by email and is for client information only.	Project Director 30th June 2023	**Medium**

Bevan Health & Wellbeing Centre (March 2023)			Previously providing 		
Ref	**Area**	**Previously agreed Action**	**Current Status**	**Revised Responsibility & Timescale**	**Priority Rating**
6	Governance- Measurable benefits	Quantified, measurable and achievable targets should be set to appraise project benefits.	Not fully Implemented UHB remarked that this was work in progress and was being taken forward by the Locality	Project Director 30th June 2023	**Low**
7	Open book- Valuation validation	The Cost Adviser should provide assurance that appropriate sampling had 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).	Not Implemented UHB confirmed that the Cost Adviser had not provided this additional information despite a request to do so.	Project Director 30th June 2023	**Low**
8	Site management – Health & Safety	Records of site inspections and audits should be presented to project forums for appropriate scrutiny and action.	Implemented Emails provided demonstrating that the appointed Site Supervisor provides a weekly NEC Supervisor Report. This is distributed to the UHB along with the UHB's advisers and the SCP. Additionally, a weekly M&E Report is provided by email, distribution	Project Director 30th June 2023	**Low**

Bevan Health & Wellbeing Centre (March 2023)			Previously providing 		
Ref	**Area**	**Previously agreed Action**	**Current Status**	**Revised Responsibility & Timescale**	**Priority Rating**
			as per NEC report, evidence as seen covers period May to October 2023.		
9.1	Change management	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.	Implemented – Change control procedures have been reviewed, updated, and actioned. The revised PEP v3 as issued 21st September 2023 records under the summary of changes that a revision has been made of internal governance change control process. This is detailed under section 9 and included under appendix D is the UHB's Change control procedures.	Project Director 30th June 2023	**Medium**
9.2	Change management	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).	Implemented Change control procedures updated and included as appendix within revised PEP.	Project Director 30th June 2023	**Medium**

Bevan Health & Wellbeing Centre (March 2023)			Previously providing 		
Ref	**Area**	**Previously agreed Action**	**Current Status**	**Revised Responsibility & Timescale**	**Priority Rating**
10	Equipping – Single tender action	Single Tender Quotation / Requests should be approved in accordance with Standing Orders / Standing Financial Instructions.	Implemented Tangible example provided of this being followed.	Project Director 30th June 2023	**High**

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Medical Equipment & Devices (Ultrasound)

Internal Audit Report

May 2024

Aneurin Bevan University Health Board

Private and confidential

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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Review reference:	AB-2324-4b
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Fieldwork commencement:	25th October 2023
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Management response received:	29th April 2024
Final report issued:	2nd May 2024
Auditors:	Stephen Chaney, Acting Head of Internal Audit Chris Scott, Internal Audit Manager
Executive sign-off:	Peter Carr, Director of Therapies and Health Science
Distribution:	Karen Hatch, Assistant Director of Therapies and Health Science Craig Roberts, Assistant Director of Therapies and Health Science Leanne Lewis, Assistant Director, Quality & Patient Safety Richard Stubbs, Risk Manager, Quality & Patient Safety David Bowkett, EBME Manager
Committee:	Audit, Risk and Assurance Committee

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

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

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

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

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

Executive Summary

Purpose

This internal audit has been undertaken to provide an opinion over the management and tracking of ultrasound devices throughout the Health Board.

Overview

Overall, whilst we found good governance architecture around the Health Board's medical equipment reviewed, sample testing of items revealed a number of weaknesses in equipment records management and accuracy.

In the sample testing of ultrasound equipment, exceptions have been raised in respect of location record errors and gaps in maintenance arrangements, although the former is being addressed through a programme of RFID tagging initiative, which was examined in our related Asset Management audit, reference AB-2324-4b (rated reasonable assurance). The findings of that review have been considered in assigning the rating of this audit.

Matters arising 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.	**N/A** No prior audit of ultrasound devices

Assurance summary[1]

Assurance objectives		Assurance
1	Policies & procedures	Reasonable
2	Inventories & registers	Limited
3	Maintenance & repair	Reasonable

Matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	MEDUSA ultrasound equipment database errors; Ultrasound equipment database and fixed assets register alignment errors	2	Operation	High
2	Ultrasound scanner equipment maintenance	3	Operation	Medium

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

1. Introduction

1.1 The review of Medical Equipment & Devices (ultrasound) was completed in line with the 2023/2024 Internal Audit Plan.

1.2 The term medical device includes all products, except medicines, used in healthcare for the diagnosis, prevention, monitoring or treatment of illness or disability. This audit assessed the controls in place for the management of ultrasound devices within the Health Board.

1.3 The Electronic and Biomedical Engineering (EBME) department maintains a medical equipment database to record the service and maintenance history of equipment and the Health Board is implementing a radio frequency identification (RFID) system to provide an efficient means of tracing equipment. This has not been reviewed as part of this audit, but rather as part of a separate audit of Asset Management.

1.4 The risks considered in this review included:

- Loss or misappropriation of equipment.
- Failure to repair, maintain and periodically replace equipment as needed.

2. Detailed Findings

Objective 1: appropriate policies and procedures are in place for the management of ultrasound equipment, either within Health Board policies or separately

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

2.2 We noted the policy and procedure documents cover a range of aspects of equipment usage and management including storage, maintenance and training in their use. In addition, a description of key roles in the management of medical equipment and devices and their respective responsibilities is also provided.

2.3 Policies make reference to relevant related safety and quality standards and incorporate sections on maintenance, repair, decontamination, equipment disposal and replacement.

2.4 The Medical Equipment & Devices Policy and associated procedure documents that we reviewed are up to date.

2.5 We were advised that policy documents are supported by a range of more specific procedure documents for particular equipment classes and for different aspects of use and management. The ultrasound equipment document is a work in progress, requires some minor amendments, but we were advised that this will be progressed to ratification through the Clinical Standards and Policy Group.

Conclusion:

2.6 We have raised no matters arising under this objective relating to policy and procedure documentation, but recognise that work is still underway for related documentation and thus, is not yet fully completed. Therefore, we have provided **reasonable assurance** over this area.

Objective 2: there is an inventory listing of ultrasound equipment, with location details recorded

2.7 We sought to establish the extent of inventory or register coverage across the range of medical equipment and devices and to assess the effectiveness of this control process in the tracking and monitoring of these items. However, this was completed primarily to identify ultrasound equipment in use.

2.8 Guidance issued by the Medicines & Healthcare products Regulatory Agency (MHRA) recommends that Healthcare organisations establish an inventory of all medical devices purchased excluding consumables. This should be recorded on to an equipment inventory. The Health Board's policy is that all new equipment must be registered on a divisional, directorate or Health Board wide inventory register, indicating the date of purchase, location and storage requirements, training and service and maintenance arrangements.

2.9 We noted that the Health Board operates a centralised database (MEDUSA Medical Equipment database) that records a substantial proportion and broad range of equipment. However, other equipment inventories/ registers are in use for particular equipment types e.g. beds, hoists. In particular, where the Health Board relies upon inventory records from the equipment providers. Additionally, there are several services e.g. Radiology, Pathology, who manage their own inventory records and where the equipment does not appear in the main MEDUSA database.

2.10 We noted that whilst the full range of equipment and devices may be captured within inventories / registers across the Health Board (not in the scope of this audit), we established that there is at present no central view of where all equipment classes are recorded and managed, including ultrasound.

2.11 A programme of RFID tagging is in progress across equipment classes including ultrasound scanners and we noted that at the time of the audit around 62% of these had a tag reference recorded in the MEDUSA database.

2.12 Our audit testing examined a small sample of ultrasound scanners, classified in the MEDUSA database as in use, to assess the accuracy of these records. We noted at the time of the audit the database listed 103 current items of this device type.

2.13 We were advised that the accuracy of the MEDUSA database is reliant upon the department to which a machine has been allocated advising the EBME department of changes to locations, equipment disposal or replacement.

2.14 Testing revealed one of the sample scanners not in the location recorded; one that had been disposed of; and one that could not be located at any site (see **Matter arising 1**).

2.15 Equipment items in the MEDUSA database that meet the criteria in terms of monetary value for capitalisation are also recorded within the Health Board's fixed asset register. However, we noted poor alignment between these two inventories / registers in respect of ultrasound scanners: only three of the audit sample of 10 scanners taken from the MEDUSA database had corresponding entries on the fixed asset register and likewise, only three of a sample of 10 equipment items on the fixed asset register had corresponding entries in the MEDUSA database (see **Matter arising 1**).

Conclusion:

2.16 We have raised a number of matters arising under this objective relating to equipment verification and records accuracy policy and procedure documentation and therefore have provided **limited assurance** over this area.

Objective 3: there is an established process and schedule to ensure ultrasound devices are maintained and kept in an appropriate state of repair, including the reporting of equipment incidents via Datix

2.17 We sought to establish that protocols for equipment maintenance, service and repair are being followed and that incidents, that involve medical equipment, are being reported, investigated and addressed in a timely manner.

2.18 The Health Board's policy dictates that divisions and their services are responsible for ensuring the provision of maintenance and servicing of the equipment they operate. Maintenance contracts and any separate quality assurance testing is the responsibility of the individual directorates.

2.19 Using ultrasound scanners as our equipment class for audit testing, typically machine care is provided by the manufacturer under a service contract and delivery of this is managed and monitored by a directorate service manager.

2.20 We examined the same sample of ultrasound scanners described above in audit objective two, but noted that for two of the machines in the sample of 10, neither the service managers nor the EBME department were able to provide maintenance contract documentation and it was unclear whether these were receiving regular attention (see **Matter arising 2**).

2.21 We noted in the 12 months to October 2023, a total of 62 Datix incidents of moderate or above rating had been reported implicating medical equipment as causal or contributory to the incident. Of these, 20 remain open at the time of this audit, the oldest is 12 months and the most recent is one month. The average is five months. However, incident reports are a standing agenda item for discussion and onwards management within the Ultrasound Governance Committee. We reviewed the outstanding incidents and confirmed that there were none outstanding related to ultrasound devices.

Conclusion:

2.22 We have raised one matter arising under this objective relating to the absence of maintenance contract provision in a number of the equipment sample items examined and therefore have provided **reasonable assurance** over this area.

Appendix A: Management Action Plan

Matter arising 1: MEDUSA ultrasound equipment database errors; Ultrasound equipment database and fixed assets register alignment errors (Operation)	Impact
We examined a sample of ultrasound scanners and using location information recorded within the MEDUSA equipment database, we sought to physically verify the sample equipment. This testing identified that: • one of the sample scanners was not in the location recorded within the database; • one that had been disposed of, but remained in the records as currently in use; and • one that could not be located at any site. We noted a poor level of alignment with the equipment listings in the MEDUSA equipment database and the Health Board's asset register when examining a sample of ultrasound scanners. Whilst the MEDUSA database retains a significant amount of information separate to the asset register, there is an expectation that there is consistency in the records of ultrasound assets in use. Overall, only three of the audit sample of 10 scanners taken from the MEDUSA database had corresponding entries in the Health Board's fixed asset register and only three of a different sample of 10 equipment items taken from the Health Board's fixed asset register had corresponding entries in the MEDUSA database. The sample selected was of equipment less than 10 years old, and that meets the capitalisation criteria (e.g. purchase cost >£5k), and we would expect to see each item appear in both record sets.	Potential risk that equipment loss or misappropriation may go undetected. Potential risk that items of equipment are omitted from the Health Board's asset register

Recommendations		Priority
1.1	We recommend that a periodic physical verification control process is implemented across the Health Board to confirm the existence of ultrasound equipment and the accuracy of its listing in the MEDUSA database. This may be done by adopting the asset management RFID tagging process underway across all assets.	High
1.2	We recommend that the Health Board carry out periodic alignment / reconciliation checks between the MEDUSA equipment database and the finance owned fixed asset register with respect to ultrasound equipment. This may also be completed via an electronic interface with the asset database	High

Management Responses		Target Date	Responsible Officer
1.1	Medusa currently holds information relating to ultrasound equipment highlighting the location and owner department. A rolling 12-month programme of staggered audit will be implemented to ensure that departments visually check the ultrasound assets against the Medusa list, reporting any issues or potential faults with the equipment to EBME. A 6-month implementation period has been assigned to this action given the need to engage with ultrasound equipment owners, design the audit process, ensure audits are recorded in an appropriate electronic format. The Ultrasound Governance Committee will represent the strategic oversight forum to review progress against the defined actions documented within the management response in support of raising assurance levels. Completing the management response to fully meet the recommendation will require Health Board employees to comply with the policy; failure by any individual to have not followed the policy will be escalated to the relevant Divisional Director.	01/11/24	Richard Stubbs, Risk Manager, Quality & Patient Safety/ David Bowkett, EBME Manager/ Divisional Directors
1.2	An electronic interface exists between the fixed asset register and MEDUSA equipment database however there is a current known fault with this interface. It is currently being addressed between EBME, Capital Finance and IT. Medusa also requires a software update to the latest revision which is also in progress. A rolling programme of audit will then be implemented to ensure reconciliation between MEDUSA and the fixed asset register (only applicable to assets where RFID has already been implemented). A 6-month period has been assigned to this recommendation given the uncertain nature of implementing the solution as well as designing an audit process and recording in an appropriate electronic format.	01/11/24	David Bowkett, EBME Manager/ Kelly Jones, Head of Capital Finance

Implementation and adherence to the audit calendar will be monitored through the Ultrasound governance committee.

Completing the management response to fully meet the recommendation will require Health Board employees to comply with the policy; failure by any individual to have not followed the policy will be escalated to the relevant Divisional Director.

Matter arising 2: Ultrasound scanner equipment maintenance (Operation)	Impact
Within the sample of ultrasound scanners tested we noted that for two of the machines in the sample of 10, the service managers were unable to provide maintenance contract documentation. With at least one of the two scanners, the service was overdue (August 2023).	Potential risk that equipment is not maintained and as a result suffers breakdown or failure

Recommendations		Priority
2.1	We recommend that services using ultrasound equipment ensure all items are covered by appropriate service or maintenance contracts and are tracked centrally.	**Medium**

Management Responses		Target Date	Responsible Officer
2.1	Monitoring of service and maintenance contracts is managed through individual departments as well as the EBME service. The physical verification audit will be utilised to ensure equipment has a current maintenance contract as well as evidence that maintenance has taken place within the prescribed period. EBME will investigate potential for MEDUSA to hold contract information centrally on MEDUSA. The system can be set up to provide Alerts. The alert can be used as an early warning indicator for both EBME and the owner that equipment is approaching a maintenance period. If, after investigation, the potential is not viable or investment	01/11/24	David Bowkett, EBME Manager/ Divisional Directors

required not available, then this particular set up on the system will not be implemented; this is not critical to the Health Board meeting the recommendation.

The Ultrasound Governance Committee will represent the strategic oversight forum to review progress against the defined actions documented within the management response in support of raising assurance levels.

Completing the management response to fully meet the recommendation will require Health Board employees to comply with the policy; failure by any individual to have not followed the policy will be escalated to the relevant Divisional Director.

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Maternity Services – Action Plan
Final Internal Audit Report

May 2024

Aneurin Bevan University Health Board

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

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Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

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Auditors:	Stephen Chaney, Interim Head of Internal Audit Rhian Gard, Audit Manager
Executive sign-off:	Jenny Winslade, Executive Nurse Director
Distribution:	Tracey Partridge-Wilson, Deputy Director of Nursing Jayne Beasley, Head of Midwifery
Committee:	Audit, Risk and Assurance Committee

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Executive Summary

Purpose

The purpose of the audit was to review the governance arrangements in place and examine the tracking and progress of maternity related actions from key recent external reviews.

Overview

We have issued substantial assurance on this area.

The overall objective of the review was to review the process for implementing maternity related actions and recommendations raised from external reviews and determine if appropriate governance arrangements are in place to implement them.

The audit ascertained the external reviews that have taken place recently and the associated actions required. These were incorporated into the Maternity and Neonatal Services in Wales Assessment, Assurance and Exception Tool which was compiled by the Welsh Government. Whilst this recorded all relevant actions, it was superseded by the Improving together for Wales: Maternity Neonatal Safety Support Programme Cymru Discovery Phase Report. The report included timeframes for the delivery of each action which included short term, medium term and long-term timeframes.

The audit also reviewed a sample of actions and associated evidence to see whether appropriate progress is being made.

Overall, within the sample tested we found regular monitoring and reporting in place, including to appropriate committees. We also confirmed that progress has been made with the implementation of the actions sampled.

Report Opinion

		Trend
Substantial 	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.	N/A – first review

Assurance summary[1]

Objectives	Assurance
1 Governance arrangements	Substantial

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

1. Introduction

1.1 The review of Maternity Services – Action Plan was completed in line with the 2023/2024 Internal Audit Plan. The review focused on the recommendations from reviews undertaken by the following agencies:

- The Royal College of Obstetricians and Gynaecologists (RCOG) undertook an external review into maternity services in Cwm Taf Morgannwg University Health Board in 2019;
- The Ockenden Report in 2022;
- MBRRACE (Mothers and babies; reducing risks through audits and confidential enquiries across the UK) report 2022;
- Health Inspectorate Wales (HIW) inspections during 202/23; and
- any other recent relevant reports and inspections

1.2 We sought to provide assurance on the process that has been adopted to implement outstanding recommendations. As part of this testing, we also selected a small sample of actions to determine the level of progress that has been completed.

1.3 The overall risk is limited progress with the implementation of actions arising from the action plan, and potentially leading to patient harm, regularly enforcement, financial loss and / or reputational damage.

2. Detailed Audit Findings

Objective: The governance arrangements over the process in place to ensure an appropriate tracking and progress of maternity related actions from recent external events.

2.1 Following recent high-profile commissioned reviews across maternity services within Wales, the Welsh Government issued a reporting tool in May 2022 to help capture the related actions which required implementation. The *Maternity and Neonatal Services in Wales Assessment, Assurance and Exception Tool* (the 'reporting tool') was used by Aneurin Bevan University Health Board (the 'Health Board') to review and priority rate the actions from the reviews and monitor its progress of implementation. This was completed through a RAG rating (red, amber or green). Amber or red ratings were requested to be raised with the Welsh Government for consideration.

2.2 The aim of the reporting tool was to assist the Health Board in allocating resources and prioritising each action. However, whilst information is provided to the Welsh Government, we were informed that there are no responsible officer details or timescales requested by the Welsh Government. As part of the audit, we reviewed the completed reporting tool and confirmed that the Health Board has regularly

reviewed and updated these actions since 2022, with evidence to support the updates tested.

2.3 Within the reporting tool there are 80 actions under five key themes: safe and effective care; family centered care; skilled multi professional teams; continuity of care; and sustainable services and workforce planning. We found that four of these actions are RAG rated amber by the Health Board and the rest of the actions are rated green and classed as either complete or in progress.

2.4 Alongside the reporting tool the *Improving together for Wales Maternity Neonatal Discovery Phase Report 2023* (the 'phase report'), which documented 124 areas for improvement across Wales, incorporated all maternity and neonatal services across Wales.

2.5 As with the reporting tool, each area for improvement was captured and assigned a RAG rating. We were informed that the Health Board was advised by the Welsh Government to focus on the non-cost options. We confirmed that these are currently in progress.

2.6 The Health Board was instructed that 13 out the 124 areas of improvement should be prioritised and progressed at pace to provide assurance within Welsh neonatal services. Out of the 13 improvement areas, eight were considered solely the responsibility of the Health Board of which five could be progressed without any additional resource. We confirmed that timescales have been assigned to the actions.

2.7 From reviewing both the reporting tool and the subsequent discovery phase spreadsheet (which superseded the reporting tool), we confirmed that all actions had been incorporated.

2.8 We tested a sample of 16 actions from both documents: seven green and four amber rated actions from the reporting tool and five actions from the discovery phase spreadsheet of which three were green and two amber rated. We tested the associated evidence that demonstrated progress and plans for implementation.

2.9 We found that four actions on the discovery phase spreadsheet are rated red. However, we confirmed that this is to maintain visibility of the ongoing work, as it may not be possible to fully implement them, as they require wider Health Board decisions. For example, one of the actions details an additional senior position to be implemented.

2.10 We confirmed that there is regular monitoring and scrutiny in place, through the IPQD (Integrated Performance Quality & Delivery) forum with the Welsh Government, which meets monthly. Within the Health Board the Maternity Neonatal Board is in place, where progress of actions and quality metrics are discussed, including enhanced scrutiny of action progress. It is also worth noting that progress updates are submitted to Patient Quality Safety and Outcomes Committee (PQSOC) and also to the wider Executive Team for review and validation.

2.11 From an extensive review of Board and PQSOC papers for 2022/23 and 2024, alongside papers submitted to the Executive Team, we confirmed regular updates on the progress of all maternity related actions takes place.

Conclusion:

2.12 We confirmed that a regular process for monitoring, tracking and escalating matters arising is in place. In addition, to regular scrutiny of current progress and priorities. We also sampled tested some outstanding actions and reviewed the evidence behind the current priority rating assigned and the implementation timeframe. We found appropriate governance arrangements in place, to ensure actions are reviewed, scrutinised and tracked regularly across different forums. Therefore, we have provided **substantial assurance** for this objective.

Management Considerations

2.13 Whilst this audit confirmed governance arrangements are in place for the tracking of progress of the actions from the external maternity and neonatal reviews, we identified some management points to consider. These optional actions are detailed below and focus on some principles for consideration, rather than specific risks to address.

1.	A defined sign off process over the implementation of maternity related actions. In particular, the sign off and recognition of the completed action is completed through the divisional or Senior Leadership Team. Once acknowledged as fully complete, the actions may be removed from the reporting tool or phase report spreadsheet. This would assist the team in concentrating on the remaining open actions, whist ensuring completed actions have sufficient scrutiny over the removal of them.
2.	Whilst the Welsh Government does not require defined implementation timescales, a more detailed implementation date e.g. end of a month for delivery, would help to prioritise actions and ensure that they are not open for completion for an extended period of time.

Appendix A: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Early Supported Discharge - Stroke
Final Internal Audit Report

May 2024

Aneurin Bevan University Health Board

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

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

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Auditors:	Simon Cookson, Director of Audit and Assurance Stephen Chaney, Interim Head of Internal Audit
Executive sign-off:	Peter Carr, Director of Therapies and Health Science
Distribution:	Collette Kiernan, Clinical Director of Therapy Services Adele Griffiths, Head of the Community Neurological Rehabilitation Service
Committee:	Audit, Risk and Assurance Committee

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

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

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

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

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

Executive Summary

Purpose

During September 2022, a GIRFT (Getting It Right First Time) report was published, following the completion of a review of stroke services that was requested by Aneurin Bevan University Health Board (the 'Health Board'). A range of recommendations were raised, but this audit focusses on the implementation of the early supported discharge (ESD) pathway.

The overall objective of the audit was to assess whether the arrangements in place for the early supported discharge of stroke patients are operating effectively.

Overview

We have issued substantial assurance on this area. The audit focused on the operational management of patients eligible for the ESD service. Overall, we found that, within the sample tested, there is a suitably documented and managed service that provided prompt rehabilitation to applicable patients that had suffered a stroke within the previous 12 weeks. The overall aim of the service is to assist with a patient's rehabilitation within a home environment.

The Team is appropriately resourced and able to meet the patients' requirements promptly, typically a triage is completed within approximately 24 to 48 hours of hospital discharge. We did not raise any recommendations, but we included a table of considerations for management on matters outside the scope of this audit, but still relevant.

Report Opinion

		Trend
Substantial 	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.	N/A – first review

Assurance summary[1]

Objectives		Assurance
1	Process and Procedures	Substantial
2	CNRS Screening Tool	Substantial
3	Home Assessments	Substantial
4	Formal Patient Reviews	Substantial

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

1. Introduction

1.1 The review for Early Supported Discharge (ESD) – Stroke was completed in line with the Aneurin Bevan University Health Board's (the 'Health Board') 2023/24 Internal Audit Plan.

1.2 This audit focused on the process from the point of hospital discharge through to discharge from the Community Neuro Rehabilitation Service (CNRS). We did this by sample testing patients referred onto the CNRS Stroke Pathway (the 'Pathway') and their progression through that process. We did not test the hospital in-patient process up to the point of discharge or subsequent follow-up appointments (e.g. consultant Hyper-acute Stroke Unit).

1.3 The Pathway offers community-based rehabilitation for adults who have recently been discharged from hospital (within 12 weeks), following a stroke. The service is only offered to suitable patients, to assist with their rehabilitation outside of a hospital environment and primarily within their home.

1.4 The service is not suitable for all stroke survivors and some patients who have been impacted with more severe or complex changes to their physical or cognitive abilities, may require a higher level of care. This support would be provided via a different treatment / rehabilitation pathway.

1.5 The overall aim of the service is to enable patients to receive rehabilitation within a community environment, immediately following their discharge from hospital. Whilst this may help reduce the patient's overall length of stay in hospital, it also provides rapid access to a multi-disciplinary team of professionals, including speech and language therapists, occupational therapists and / or clinical psychologists.

1.6 The number of patients referred onto the Pathway varies from 300 to 450 each year. A patient suitable for referral spent, on average, 3.6 days within an acute stroke hospital ward (circa. 19.4 days where the Pathway is not suitable for patients).

1.7 The average time a patient would spend waiting to access the service is 2.5 days (4.8 days for patients discharged on a Friday, Saturday or Sunday). Patients discharged from hospital between Monday and Thursday receive an initial assessment within 1.6 days, on average.

1.8 As a result of this approach, an estimated average of 3.81 bed days in an acute environment were saved for each patient that was discharged earlier than they would have been if the Pathway did not exist.

1.9 The risks in this review included:

- change in patient's condition leading to an inappropriate stroke pathway being applied and resulting in patient harm;
- patients do not receive appropriate clinical support;
- assessments are not completed in a timely manner, potentially resulting in patient harm;

- demand for early supported discharge services exceeds capacity potentially leading to patient harm; and
- lack of awareness of key early supported discharge processes, resulting in patient harm and / or an inefficient use of resources.

2. Detailed Audit Findings

Objective 1: The process for early supported discharge is appropriately documented and communicated.

2.1 The CNRS Stroke Pathway is a key documented process that sets out the referral and treatment steps for suitable patients. Early supported discharge (ESD) should be quick, responsive, and intensive. To achieve this, the Health Board operates with a multi-disciplinary team, to rapidly provide the necessary services.

2.2 We reviewed this document and assessed the content against the requirements of the NICE guideline: Stroke Rehabilitation in Adults[1] (the 'Guidelines'). The process is consistent with the key requirements, including contact and patient support, and was evidenced by our walkthrough of the actual process steps in place.

2.3 The Guidelines refer to a patient's six month and annual stroke review. This is not included within the Pathway document, as it is managed via the hospital outpatient process, including consultants and the Hyper-acute Stroke Unit, which was not tested as part of this review.

2.4 Following a patient referral, a triage assessment is completed, to determine the level of support initially required. We confirmed within the sample tested that this was largely completed either the same day or the following working day.

2.5 Whilst the expectation is that periodic patient reviews would take place (e.g. after six and 12 weeks), in reality this is an ongoing process from the triage stage until the patient has received the full level of support required. We found that there was considerable interaction and engagement with the patients throughout this stage of the process.

2.6 To implement the process, we found the CNRS Team to be appropriately resourced, engaging with patients typically within approximately 48 hours of hospital discharge, although this can take slightly longer where the discharge occurs on a Friday. This enables a rapid response to each patient deemed suitable for the team's support.

Conclusion:

2.7 Overall, the process meets the expected requirements and matches our walkthrough of the steps undertaken by the CNRS Team. There are no issues to raise and consequently we have provided **substantial assurance** for this audit objective.

[1] Overview | Stroke rehabilitation in adults | Guidance | NICE

Objectives 2, 3 and 4: Adherence to the CNRS Stroke Pathway Process

2.8 We selected a sample of 20 patients referred onto the Pathway and subsequently discharged, to determine if the process was adhered to. As the CNRS Team operates across three geographical areas within the Gwent region (North, South and West), we selected a sample across each of these.

2.9 17 of the 20 patient files requested were available for reviewing, with one file across each area unavailable for testing purposes. The three files unavailable for testing may not have yet been archived. However, the remaining sample selected was suitable to draw conclusions upon.

2.10 We undertook testing across the end-to-end process, from the inwards referral to the discharge from the service. In total, we examined the screening; triage; ongoing CNRS assessment and treatment; and the discharge process elements.

2.11 Overall, there were no matters arising identified. We identified some minor queries that were promptly resolved, and we confirmed that one patient within the sample tested declined support from the service, but otherwise the expected process was adhered to.

2.12 Whilst we did not assess the clinical suitability of the service and support provided, we reviewed the patient records to confirm that frequent occupational therapists (and other professional) visits were taking place, alongside a range of other support, if required.

2.13 We also confirmed that the service does not end abruptly (e.g. at the end of 12 weeks). The engagement is ongoing and continues for as long as a benefit is provided. Within our sample, the average number of days for each patient within the Pathway was 58.3 days. The average number of hours of support provided by the CNRS Team was 12 hours, but this varied from several hours to 66.5 hours. The median length of support provided was just over seven hours.

2.14 We also identified that the CNRS Team still reached out to offer support, even when it has been declined. Furthermore, where a patient may not be suitable for the Pathway (e.g. their requirements are too complex), select support services may still be offered if there is a perceived benefit, e.g. speech and language therapy.

Conclusion:

2.15 The sample tested encompassed audit objectives two, three and four. We identified no significant exceptions within our testing. We also observed the CNRS Team were able to offer support flexibly, by reallocating resource, when required and to respond to additional patients requiring support in a timely manner. Therefore, we have provided **substantial assurance** for these objectives.

Management Considerations

2.16 Whilst this audit examined the operational processes for the management of the Pathway, we identified some points for management to consider with any future development of the service. We have not raised these as recommendations, as they did not form part of our testing against the scope of the audit. These are detailed below.

1.	Periodically review the ease of access for patients that can benefit from the ESD service. For example, how patients may be referred onto the Pathway from other geographical areas, or patients that may have moved into the area.
2.	Consideration to extending the service to other patients that have experienced a stroke and that may not currently meet the ESD criteria. In addition, other patients that may not have been referred, but may still be eligible.
3.	Undertake a periodic evaluation of the overall service and experience provided to patients. Any feedback received should be considered when developing the medium to longer term service strategy.
4.	Review the current archive process to establish the parameters for a record to be archived and the criteria for creating a record in the first instance, for example, patients that decline the service.
5.	There are numerous fields completed that include patient data / metrics e.g. the Barthel Score. However, these cells are not always completed. There is a benefit in determining exactly what should be completed and to utilise these metrics to help inform management of the benefits of the service.
6.	Review the intranet to determine if the information published remains consistent with the current process, for example, the six week review.

Appendix A: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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Archwilio Cymru
Audit Wales

Aneurin Bevan University Health Board – Detailed Audit Plan 2024

Audit year: 2023-24

Date issued: April 2024

Document reference: 4110A2024

This document is a draft version pending further discussions with the audited and inspected body. Information may not yet have been fully verified and should not be widely distributed.



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

About Audit Wales

Our aims and ambitions

Assure



the people of Wales that public money is well managed

Explain



how public money is being used to meet people's needs

Inspire



and empower the Welsh public sector to improve



Fully exploit our unique perspective, expertise and depth of insight



Strengthen our position as an authoritative, trusted and independent voice



Increase our visibility, influence and relevance



Be a model organisation for the public sector in Wales and beyond

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Introduction

I have now largely completed my planning work.

This Detailed Audit Plan specifies my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice.

It sets out the work my team intends undertaking to address the audit risks identified and other key areas of focus during 2024.

It also sets out my estimated audit fee, details of my audit team and key dates for delivering my audit team's activities and planned outputs.



Adrian Crompton
Auditor General for Wales

Audit of financial statements

I am required to issue a report on your financial statements which includes an opinion on their 'truth and fairness' and the regularity of income and expenditure. and the proper preparation of key elements of your Remuneration and Staff Report. I lay them before the Senedd together with any report that I make on them. I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities.

I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The levels at which I judge such misstatements to be material is set out later in this plan.

I am also required to certify a return to the Welsh Government which provides information about the Health Board to support preparation of the Whole of Government Accounts.

There have been no limitations imposed on me in planning the scope of this audit.

Performance audit work

I must satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance audit work each year.

My work programme is informed by specific issues and risks facing the Health Board and the wider NHS in Wales. I have also taken account of the work that is being undertaken or planned by other external review bodies and by internal audit.

My performance audit work is designed to comply with auditing standards set out by the International Organisation of Supreme Audit Institutions (INTOSAI). This is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special consultative status with the Economic and Social Council (ECOSOC) of the United Nations

Your audit at a glance



My financial statements audit will concentrate on your risks and other areas of focus

My audit planning has identified the following risks:

Significant financial statement risk:

- Management override.

Other areas of audit focus:

- Financial duty;
- Losses and special payments;
- Asset verification;
- Related party disclosures;
- Senior officer remuneration; and
- Provisions and contingent liabilties.



My performance audit will include:

Structured Assessment – core
Structured Assessment – deep dive review of deep dive review of investment in digital systems to support service resilience and transformation
All-Wales Thematic Review – managing demand for urgent and emergency care
Local work – Review of Eye Care Services



Materiality

Materiality	£17.864million
Reporting threshold	£0.893million

Financial statements' materiality



Materiality £17.864m

My aim is to identify and correct material misstatements, that is, those that might other cause the user of the accounts into being misled.

Materiality is calculated using:

- 2023-24 gross expenditure which is estimated using 2022-23 actual expenditure of £1,786 million. This will be updated at final audit stage.
- Materiality percentage of 1%

I report to those charged with governance any misstatements above a trivial level (set at 5% of materiality).



Areas of specific interest

There are some areas of the accounts that may be of more importance to the user of the accounts, and we have set a lower materiality level for these:

- Remuneration report – £5k (or correct banding) for the "Salary and Pension entitlements of Senior Managers Remuneration" table; and
- Related party disclosures - £10k for individual interests.

Significant financial statements' risks

Significant risks are identified risks of material misstatement for which the assessment of inherent risk is close to the upper end of the spectrum of inherent risk or those which are to be treated as a significant risk in accordance with the requirements of other ISAs. The ISAs require us to focus more attention on these significant risks.

Exhibit 1: significant financial statement risks

Significant risk	Our planned response
Management override The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].	The audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for bias; and • evaluate the rationale for any significant transactions outside the normal course of business.

Other areas of focus

I set out other identified risks of material misstatement which, whilst not determined to be significant risks as above, I would like to bring to your attention.

Exhibit 2: other areas of focus

Audit risk	Our planned response
Financial Duty The position at month 11 shows a year-to-date deficit of £47.6 million and a forecast year-end deficit of £49.9 million which is in excess of the Minister's published control total. This, combined with the outturns for 2021-22 and 2022-23, predicts a three-year deficit of £86 million. Where you fail this financial duty, we will place a substantive report on the financial statements highlighting the failure and qualify your regularity opinion.	The audit team will: • continue to monitor the Health Board's financial position for 2023-24 and the cumulative three-year position to 31 March 2024. • undertake testing on areas of the financial statements which contain judgements such year-end accrual to ensure transactions have been reported in the correct reporting accounting period; and • consider the impact of any relevant uncorrected misstatements over the three years.
Losses and special payments register From 1 December 2023, the Losses and Special Payments Register (LaSPaR), used to calculate the losses and many of the provisions balances in the accounts, has been de-commissioned. For the remainder of 2023-24, a model excel spreadsheet on an All Wales basis will be used to record losses, special payments and to calculate year-end balances. There is a risk that the transactions and balances related to losses and special payments are materially misstated due to: • the data transfer between the LaSPaR system and the excel model not being complete and accurate; and/or	The audit team will: • Test the completeness and accuracy of data transfer from the LaSPaR system to the excel based spreadsheets; • consider the design and implementation of controls (if any) in place to mitigate error; • review the year-end spreadsheet to ensure that there are no significant errors or issues in the compilation of figures for the accounts; and • review transactions back to supporting evidence (e.g. Quantum reports) on a sample basis.

Audit risk	Our planned response
• the excel model miscalculating balances, due to spreadsheet/modelling errors and/or incorrect data entry.	
Related Parties and Senior Officer Remuneration Some of the disclosures in the financial statements, such as related parties and the remuneration report, are judged to be material by nature, with a far lower level of materiality. These disclosures are therefore inherently prone to material misstatement.	The audit team will: • examine all entries in the remuneration report to verify that they are materially accurate, and that remuneration has been paid at the approved levels; and • verify that all necessary signed declarations have been received, evaluated and disclosed appropriately and accurately.
Asset verification In the previous two audits, issues have been identified regarding the verification of existence of non-current assets held on the balance sheet, particularly those held at nil Net Book Value. There is therefore a risk that the balance sheet is materially misstated	My audit team will undertake testing to verify the existence of assets on the balance sheet.
Provisions and contingent liabilities Provisions and contingent liabilities are measured at the best estimate of the expenditure required to settle present obligations. Due to the level of estimation involved in the calculation of provisions, there is a risk that provisions are susceptible to management over-ride. The audit of the 2022-23 financial statements identified misclassification of some provision and contingent liability balances. This is therefore an area of audit risk.	My audit team will: • test the appropriateness of these balances; • review the estimates for bias; and • test the appropriateness of the classification of balances.

Financial statements' audit timetable

I set out below key dates for delivery of my accounts audit work and planned outputs.

Exhibit 3: key dates for delivery of planned outputs

Planned output	Work undertaken	Report finalised
2024 Detailed Audit Plan	April 2024	May 2024
Audit of financial statements work: Audit of Financial Statements Report Opinion on the Financial Statements	May to July 2024	July 2024

Planned performance audit work

I set out below details of my performance audit work and key dates for delivery of planned outputs.

Exhibit 4: key dates for delivery of planned outputs

Area of Work	Scope of work	Planned timescales
Structured Assessment - core	Structured assessment will continue to form the basis of the work my audit teams do at each NHS body to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. My core 2024 structured assessment work will review the following areas: • Board and committee cohesion and effectiveness. • Corporate systems of assurance. • Corporate planning arrangements; and • Corporate financial planning and management arrangements. My structured assessment work will also include a review of the arrangements that are in place to track progress against previous audit recommendations. This allows the audit team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables us to more explicitly measure the impact our work is having.	Fieldwork to commence between June and August 2024 with reporting by the end of October 2024.
Structured Assessment - deep dive review of investment in digital systems to support service resilience and transformation	In addition to the core structured assessment work described above, my audit teams will also review certain arrangements at NHS bodies in more depth. This year, my audit teams will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency. This work was deferred from 2023, following my decision to replace the work with a review of the Health Board's approach to financial efficiencies.	Fieldwork to commence during the autumn of 2024 and reporting by the end of March 2025.

Area of Work	Scope of work	Planned timescales
All Wales thematic review of urgent and emergency care – managing demand for urgent and emergency care	In my 2020 audit plan for the Health Board, I set out my intention to undertake work to examine arrangements to manage demand for urgent and emergency care services, as part of my wider work focused on these services. Due to the COVID-19 pandemic, I deferred this work to allow NHS bodies to respond to the pandemic, with a plan to bring the work back online once the impact of the pandemic had subsided and my work on patient flow out of hospital was completed. I am now able to take forward my work on managing demand for urgent and emergency care. The work will be undertaken during 2024 and will be funded from this year's audit fee. Consequently, I have decided to refund the Health Board the fee paid for this work as part of my 2020 audit plan. My 2024 urgent and emergency care work will focus on: The robustness of plans to manage the demand on urgent and emergency care services; The effectiveness of arrangements to encourage and enable people to access the right care, in the right place, at the first time; and The effectiveness of arrangements to monitor the performance of urgent and emergency care services and apply lessons learnt to improve the services further.	Fieldwork commenced in February 2024 and reporting by the end of September 2024.
Local project work – Review of Eye Care Services	My audit team will also undertake performance audit work that reflects issues specific to the Health Board. Following on from my report on orthopaedic services review last year, my team will review the Health Board's speciality with the second highest level of elective waits – ophthalmology – as part of a wider review of eye care services that will also consider community based eye care services.	Fieldwork expected to commence October 2024 and reporting by April 2025.

Area of Work	Scope of work	Planned timescales
	My team will share further details of the focus of this review once we have completed our scoping work..	

Fee and audit team

In January 2024 we published our Fee Scheme for the 2024-25 year as approved by the Senedd Finance Committee. My fee rates for 2024-25 have increased by an average of 6.4% as a result of unavoidable inflationary pressures and the ongoing need to invest in audit quality.

I estimate your total audit fee will be £454,611. This represents an increase of around 8.1%. which takes into account the inflationary pressures and audit quality requirements mentioned above as well as the risks the Health Board is facing.

Planning will be ongoing, and changes to my programme of audit work, and therefore my fee, may be required if any key new risks emerge. I shall make no changes without first discussing them with the Executive Director of Finance & Procurement.

Our financial audit fee is based on the following assumptions:

- The agreed audit deliverables set out the expected working paper requirements to support the financial statements and includes timescales and responsibilities.
- No matters of significance, other than as summarised in this plan, are identified during the audit.

Exhibit 5: breakdown of audit fee

Audit area	Proposed fee for 2024 (£)[1] [2]	Actual fee for 2023 (£)
Audit of Financial Statements	**270,805**	**254,516**
Performance audit work:		
Structured Assessment (including deep dive review)	£100,331	£86,441
All Wales Thematic Review	£43,568	£46,622
Local Project Work	£39,907	£33,103
Performance work total	**£183,806**	**£166,166**
Total fee	**£454,611**	**£420,682**

[1] The fees shown in this document are exclusive of VAT, which is not charged to you.

[2] We are awaiting confirmation of any pooled budgets that require auditing. These will incur additional fee.

The main members of my team, together with their contact details, are summarised in **Exhibit 6**.

Exhibit 6: my local audit team

Name	Role	Contact details
Richard Harries	Engagement Director (Financial Audit)	Richard.Harries@audit.wales
Dave Thomas	Audit Director (Performance Audit)	Dave.Thomas@audit.wales
Julie Rees	Audit Manager (Financial Audit)	Julie.rees@audit.wales
Andrew Doughton	Audit Manager (Performance Audit)	Andrew.Doughton@audit.wales
Angharad Clemens	Audit Lead (Financial Audit)	Angharad.clemens@audit.wales
Sara Utley	Audit Lead (Performance Audit)	Sara.utley@audit.wales

I can confirm that my team members are all independent of the body and your officers.

Audit quality

Our commitment to audit quality in Audit Wales is absolute. We believe that audit quality is about getting things right first time.

We use a three lines of assurance model to demonstrate how we achieve this. We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by QAD* and our Chair, acts as a link to our Board on audit quality. For more information see our Audit Quality Report 2023.



Our People

The first line of assurance is formed by our staff and management who are individually and collectively responsible for achieving the standards of audit quality to which we aspire.

- Selection of right team
- Use of specialists
- Supervisions and review



Arrangements for achieving audit quality

The second line of assurance is formed by the policies, tools, learning & development, guidance, and leadership we provide to our staff to support them in achieving those standards of audit quality.

- Audit platform
- Ethics
- Guidance
- Culture
- Learning and development
- Leadership
- Technical support



Independent assurance

The third line of assurance is formed by those activities that provide independent assurance over the effectiveness of the first two lines of assurance.

- EQCRs
- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

* QAD is the quality monitoring arm of ICAEW.

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Audit Wales has developed a range of resources to support the scrutiny of Welsh public bodies and to support those bodies in continuing to improve the services they provide to the people of Wales.

Visit our website to find:

	our **Good Practice** work where we share emerging practice and insights from our audit work in support of our objectives to assure, to explain and to inspire.
	our **newsletter** which provides you with regular updates on our public service audit work, good practice, and events.
	our **publications** which cover our audit work completed at public bodies.
	information on our **forward performance audit work programme 2023-2026** which is shaped by stakeholder engagement activity and our picture of public services analysis.
	various **data tools** and **infographics** to help you better understand public spending trends including a range of other insights into the scrutiny of public service delivery.

You can find out more about Audit Wales in our Annual Plan 2024-25 and Our Strategy 2022-27.



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Archwilio Cymru
Audit Wales

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

Date issued: May 2024

Document reference: 3997A2024

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

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.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

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

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About this document

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

2 We also provide additional information on:

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

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

Accounts audit update

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

Exhibit 1 – Accounts audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Audit of Accounts 2023-24	Rob Holcombe – Director of Finance and Procurement	We will follow the audit approach designed as part of our planning work and undertake appropriate audit testing to enable to Auditor General to provide his opinions on the financial statements of the Health Board.	Final accounts audit due to start 7th May	Audit of Accounts report presented to the July 2024 Audit, Risk and Assurance Committee
Audit of Charitable Fund Accounts 2023-24	Rob Holcombe – Director of Finance and Procurement	We will follow the audit approach designed as part of our planning work and undertake appropriate audit testing to enable to Auditor General to provide his opinion on the financial statements of the Charitable Fund.	Not started	To be confirmed

Performance audit update

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

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment 2023 – Deep dive on financial efficiencies	Chief Executive Officer	In addition to the core structured assessment work, we will also undertake "deeper dive" work in a specific area. We had initially identified digital transformation as the deeper dive topic for 2023. However, given the financial challenges facing the NHS at present, we are looking to now focus our deep dive work in health boards on financial savings / cost improvement plans.	Fieldwork complete	July 2024
Review of Unscheduled Care	Chief Operating Officer	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the	Part 1 – Regional report in internal clearance	To be confirmed

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		unscheduled care system is currently working. The work will include an examination of the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow (Part 1). We also plan to review progress being made in managing unscheduled care demand by helping patients access services which are most appropriate for their unscheduled care needs (Part 2).	Part 2 – Project brief issued	
Quality Governance Review Follow up	Executive Director of Nursing Medical Director Executive Director of Therapies and Health Sciences	The work will assess the extent to which previous audit recommendations arising from our thematic review of Quality Governance arrangements have been implemented and are delivering the intended outcomes / benefits. It will also focus on the Health Board's preparedness for the Duty of Quality and Candour and the effectiveness of its governance arrangements in providing assurance over its compliance.	Planning	To be confirmed

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
All-Wales thematic review of planned care	Chief Operating Officer	This work will follow on from the national report on tackling the planned care backlog. Whilst the exact focus of this work is still to be determined, it is likely to consider: • The extent that health boards have achieved Welsh Government targets for recovering planned care services; • The efficacy of local plans and activity to recover waiting lists; and • Use of the additional Welsh Government financial allocations to improve waiting lists.	Scoping Project brief to be issued in May 2024	To be confirmed

Other relevant publications

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

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

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

Additional information

7 Exhibit 4 provides information on corporate documents published by Audit Wales since the last committee update. Links to the documents on our website are provided. There are no relevant Audit Wales consultations currently underway.

Exhibit 4 – Audit Wales corporate documents

Title	Publication Date
Annual Plan 2024-25	April 2024

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

Archwilio Cymru
Audit Wales

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

Audit year: 2022

Date issued: December 2023

Document reference: 3654A2023

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

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

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

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

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Summary report

Introduction

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

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

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

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

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

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

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

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

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

Key findings

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

Implementation of previous audit recommendations

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

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

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

Board-level visibility and focus on primary care

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

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

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

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

Capacity and capability to deliver local and national priorities

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

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

Recommendations

Implementation of previous audit recommendations

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

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

Exhibit 1: status of our 2019 recommendations

Implemented	Ongoing	No action	Superseded	Total
7	8	0	1	16

Detailed report

Implementation of previous audit recommendations

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

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

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

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

Investment in primary care

21 We considered whether the Health Board has:

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

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

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

New ways of working

24 We considered whether the Health Board has:

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

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

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

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

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

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

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

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

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

Neighbourhood Care Networks

30 We considered whether the Health Board has:

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

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

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

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

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

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

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

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

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

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

Board-level oversight of primary care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Capacity and capability to deliver local and national priorities

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

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

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

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

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

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

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

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

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

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

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

Appendix 1

Audit methods

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

Exhibit 3: audit methods

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

Appendix 2

A summary of progress against our 2019 recommendations

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

Exhibit 4: our recommendations from 2019

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

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

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

Appendix 3

Organisational response to audit recommendations

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

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

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

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



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