

Audit, Risk and Assurance Committee

Tue 18 February 2025, 09:30 - 12:30

Microsoft Teams

Agenda

09:30 - 09:30 **1. Preliminary Matters**

0 min

 20250218 Audit Risk and Assurance Agenda.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 on 12 November 2024

Attached Chair

 20250218 1.4 Audit Risk and Assurance Committee Minutes November Chair Approved.pdf (14 pages)

1.5. Committee Action Log and Matters Arising

Attached Chair

 20250218 1.5 Audit Risk Assurance Committee Action Log November 24 - Chair Approved.pdf (3 pages)

1.5.1. Update on Implementation of Job planning

Attached Strategic Lead Medical & Dental Workforce

 20250218 1.5.1 Final 04.02.02 Job Planning Assurance Note.pdf (3 pages)

 20250218 1.5.1 Appendix 1 Divisional Job Plan Compliance 90% target.pdf (1 pages)

1.5.2. Delivery of the Clinical Audit plan

Attached Assistant Director for Quality and Patient Safety

 20250218 1.5.2 SBAR Final ARA delivering clinical audit plan Feb 2025.pdf (5 pages)

 20250218 1.5.2 ARA report Feb 2025 Final.pdf (15 pages)

09:30 - 09:30 **2. Items for APPROVAL/RATIFICATION/DECISION**

0 min

2.1. Development of Committee Annual Programme of Business 2025/26

Attached Director of Corporate Governance

 20250218 2.1 Development of the ARA Committee Forward Work Programme 2025-26.pdf (4 pages)

 20250218 2.1 Appendix 1 ARA_Committee Work Programme 2025-26 Final.pdf (7 pages)

2.2. To Receive Audit Recommendations Tracking Report – to include an update on

outstanding Discharge Planning Internal Audit Actions

-  20250218 2.2 Internal_External Audit Recommendations Cover Report February ARAC.pdf (9 pages)
-  20250218 2.2 Appendix A Revised Implementation Dates.pdf (6 pages)
-  20250218 2.2 Appendix B Residual Overdue Recommendations.pdf (1 pages)
-  20250218 2.2 Appendix C Completed Recommendations.pdf (12 pages)
-  20250218 2.2 Appendix D Recommendations Exceeding Extension Threshold.pdf (7 pages)
-  20250218 2.2 Appendix E Discharge Planning 2022 Progress Overview.pdf (4 pages)

2.3. To Approve Reviewed and Updated Financial Control Procedures

Attached *Director of Finance and procurement*

- Counter Fraud Bribery and Corruption Policy
- Local Counter Fraud Specialist and Workforce and OD Joint Working Protocol
- Counter Fraud and Internal Audit Joint Working Protocol
- Counter Fraud Communication Strategy

-  20250218 2.3 Finance Governance Report - 18.02.2025.pdf (9 pages)
-  20250218 2.3.1 Appendix 1 ABUHB_Finance_0278 Counter Fraud Bribery and Corruption Policy Final v2.pdf (38 pages)

09:30 - 09:30
0 min

3. ITEMS FOR DISCUSSION

3.1. Receive Report of the use of Single Tender Action

Attached *Director of Finance and procurement*

-  20250218 3.1 Single Tender Action Report - 19.10.2024 - 24.01.2025.pdf (3 pages)
-  20250218 3.1.1 Appendix A - Single Tender Action Report - 19.10.2024 - 24.01.2025.pdf (4 pages)

3.2. To Receive Committee Risk & Assurance Report

Attached *Director of Corporate Governance*

-  20250218 3.2 Risk and Assurance Cover Report Feb 2025.pdf (7 pages)
-  20250218 3.2 Appendix A Strategic Risk Dashboard and Assessments.pdf (45 pages)

3.3. Receive the Counter Fraud Annual Report including Counter Fraud annual workplan 2025/26 approval

Attached *Head of Counter Fraud*

-  20250218 3.3 Annual Plan 25-26 Cover Sheet.pdf (4 pages)
-  20250218 3.3.1 ARAC Counter Fraud Report 2 2024-25_ (002).pdf (10 pages)
-  20250218 3.3.2 ABUHB Counter Fraud Work Plan 2025-2026 copy (002).pdf (11 pages)
-  20250218 3.3.3 Appendix 2 - Fraud Risk Profile ABUHB.pdf (7 pages)

3.4. Receive Internal Audit Progress Report

Attached *Head of Internal Audit*

-  20250218 3.4 ABUHB February 2025 Audit Committee Progress Report.pdf (9 pages)

3.5. Receive Internal Audit Review Reports

Oral *Head of Internal Audit*

3.5.1. Records Management - limited assurance

Attached *Head of Internal Audit*

-  20250218 3.5.1 ABUHB-2425-16 Records Management Audit - Final Internal Audit Report for Client.pdf (16 pages)

3.5.2. Declaration of Interests – substantial assurance

Attached Head of Internal Audit

 20250218 3.5.2 ABUHB 2024.25 Declaration of Interests FINAL Report.pdf (8 pages)

3.5.3. Intelligence Led Organisation - reasonable assurance

Attached Head of Internal Audit

 20250218 3.5.3 ABU-2425-22 Intelligence Led Organisation FINAL IA Report.pdf (23 pages)

3.5.4. End of Life Care - reasonable assurance

Attached Head of Internal Audit

 20250218 3.5.4 ABU 2425-11 FINAL EoL Internal Audit Report .pdf (8 pages)

3.6. Receive External Audit Progress Report 2024/25

Attached Audit Wales

 20250218 3.6 3997A2024 Audit Risk and Assurance Committee Update - February 2025.pdf (14 pages)

3.7. Receive Audit Wales' review of Cost Efficiencies

Attached Audit Wales

 20250218 3.7 4648A2024 ABUHB Cost Savings Arrangements.pdf (24 pages)

3.8. Receive Audit Wales' Structured Assessment Report 2024

Attached Audit Wales

 20250218 3.8 4510A2024 ABUHB Structured Assessment Report.pdf (44 pages)

3.9. Receive Audit Wales' Annual Audit Report 2024

Attached Audit Wales

 20250218 3.9 4696A2025 ABUHB Annual Audit Report.pdf (22 pages)

3.10. Receive Audit Wales' Outline Audit Plan 2024

Attached Audit Wales

 20250218 3.10 Aneurin Bevan UHB 2025 Outline Audit Plan.pdf (10 pages)

3.11. To consider the approach and timelines for the Annual Report and Accounts

Attached Director of Corporate Governance & Director of Finance and procurement

 20250218 3.11 Development of Annual Report ARAC.pdf (5 pages)

09:30 - 09:30
0 min

4. ITEMS FOR INFORMATION

4.1. No Items for Information

09:30 - 09:30
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: Tuesday 22nd April 2025

AUDIT, RISK & ASSURANCE COMMITTEE AGENDA

Date and Time

Tuesday 18th February 2025 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 12 November 2024	Attached	Chair
1.5	Committee Action Log and Matters Arising - Implementation of Job planning. - Delivery of the Clinical Audit plan.	Attached	Chair Strategic Lead Medical & Dental Workforce Assistant Director for Quality and Patient Safety
2	ITEMS FOR APPROVAL/RATIFICATION/DECISION		
2.1	Development of Committee Annual Programme of Business 2025/26	Attached	Director of Corporate Governance
2.2	To Receive Audit Recommendations Tracking Report – to include an update on outstanding Discharge Planning Internal Audit Actions	Attached	Director of Corporate Governance
2.3	To Approve Reviewed and Updated Financial Control Procedures - Counter Fraud Bribery and Corruption Policy - Local Counter Fraud Specialist and Workforce and OD Joint Working Protocol	Attached	Director of Finance and procurement



	- Counter Fraud and Internal Audit Joint Working Protocol - Counter Fraud Communication Strategy		
3	ITEMS FOR DISCUSSION		
3.1	Receive Report of the use of Single Tender Action	Attached	Director of Finance and procurement
3.2	To Receive Committee Risk & Assurance Report	Attached	Director of Corporate Governance
3.3	Receive the Counter Fraud Annual Report including Counter Fraud annual workplan 2025/26 approval	Attached	Head of Counter Fraud
3.4	Receive Internal Audit Progress Report	Attached	Head of Internal Audit
3.5	Receive Internal Audit Review Reports.	Attached	
3.5.1	Records Management - limited assurance	Attached	
3.5.2	Declaration of Interests – substantial assurance	Attached	
3.5.3	Intelligence Led Organisation - reasonable assurance	Attached	
3.5.4	End of Life Care - reasonable assurance	Attached	Audit Wales
3.6	Receive External Audit Progress Report 2024/25	Attached	
3.7	Receive Audit Wales’ review of Cost Efficiencies	Attached	
3.8	Receive Audit Wales’ Structured Assessment Report 2024	Attached	
3.9	Receive Audit Wales’ Annual Audit Report 2024	Attached	
3.10	Receive Audit Wales’ Outline Audit Plan 2024	Attached	Director of Corporate Governance
3.11	To consider the approach and timelines for the Annual Report and Accounts	Attached	



			and Director of Finance and procurement
4	ITEMS FOR INFORMATION		
	No Items for Information		
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 22 nd April 2025		

Motion to Exclude Members of the Public and the Press

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





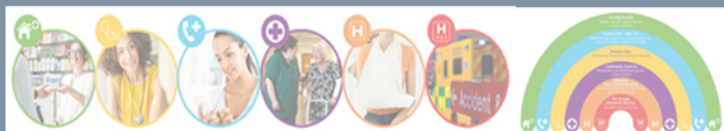
GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN/ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING MINUTES OF THE AUDIT RISK & ASSURANCE COMMITTEE

DATE OF MEETING	Tuesday 12 November 2024
VENUE	Microsoft Teams

PRESENT	Iwan Jones - Committee Chair – Independent Member
	Dafydd Vaughan - Independent Member
	Neil Patrick - Independent Member
IN ATTENDANCE	Rani Dash - Director of Corporate Governance
	Rob Holcombe - Director of Finance and Procurement
	Mark Ross - Assistant Finance Director
	Stephen Chaney - Senior Auditor, Internal Audit, NWSSP
	Murray Gard - Senior Auditor, Internal Audit, NWSSP (<i>Item 3.8</i>)
	Sara Utley - Performance Audit Lead, Audit Wales
	Julie Rees - Audit Wales Finance Audit Lead, Audit Wales
	Jonathan Simms - Clinical Director of Pharmacy (<i>Item 3.2</i>)
	James Calvert - Medical Director (<i>Items 3.3 and 3.4</i>)
	Amanda Legge - All Wales Post Payment Verification Manager (<i>Item 3.5</i>)
OBSERVING	Sara Jeremiah - Post Payment Verification Location Manager (<i>Item 3.5</i>)
	Danielle Jackson - Secretariat
OBSERVING	Kelly Jones - Head of Capital Finance



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

APOLOGIES	Richard Clark - Committee Vice Chair - Independent Member Lucy Windsor - Head of Corporate Risk and Assurance

Minute Reference	Preliminary Matters
ARAC 1211/01	Welcome and Introductions The Chair welcomed everyone to the meeting.
ARAC 1211/02	Apologies for Absence Apologies were noted.
ARAC 1211/03	Declarations of Interest There were no declarations of interest raised to record.
ARAC 1211/04	Minutes of the previous meeting The minutes of the meeting held on the 12 September 2024 were agreed as a true and accurate record. Iwan Jones (IJ), Committee chair, requested that due to the lack of assurance that was provided by the Clinical Audit update presented at the September meeting a further update be brought to the next scheduled meeting in February 2025 to provide additional assurance. ACTION: Secretariat/Assistant Director Quality and Patient Safety Neil Patrick (NP), Independent Member asked, in relation to ARAC 12/09 Waiting List Management Audit, if it would be possible to consider demand increase as well as capacity. Rob Holcombe (RH), Director of Finance and Procurement, advised that a demand and capacity model was completed in conjunction with the annual plan on a yearly basis. Over the last year there have been deep dives into three areas with the highest levels of demand; Ophthalmology, Orthopaedics and ENT. A report on planned care performance was due to be presented to the Board on 26 th November 2024.
ARAC 1211/05	Committee Action Log The Committee reviewed the action log, noting actions completed, actions in progress, and actions not yet due. The Committee AGREED that completed actions could be removed from the Action Log.
ITEMS FOR APPROVAL / RATIFICATION / DECISION	



Audit Recommendations Tracker

Rani Dash (RD), Director of Corporate Governance, reported on the status of audit recommendations as of 31 September 2024, noting that 17 recommendations were completed, deadlines for 22 were revised, and 3 remained overdue.

It was noted that 3 of the 17 revised deadline requests had exceeded the extension threshold determined by the committee at its last meeting of 2 requests and therefore a detailed note for each recommendation had been provided for assurance.

Iwan Jones (IJ), Committee Chair, raised concerns regarding the progress of recommendations from the 2022 Discharge planning audit report and requested that additional review be completed to provide assurance.

RD informed the committee that an External audit review of discharge planning was scheduled to be brought to the next committee and suggested that an update of current internal audit recommendations be brought alongside the report.

ACTION: Secretariat/Director of Corporate Governance.

Dafydd Vaughan (DV), Independent Member, highlighted that a number of recommendations within the tracker were reliant on IT changes or digital solutions and questioned whether the Director of Digital has had the correct level of involvement and oversight of the review to ensure that digital capacity and support is available to allow these recommendations to progress.

RD reinforced that at the previous meeting the quality assurance process around management responses was agreed to ensure alignment across matrix type actions and therefore going forward this oversight will improve.

The Committee **APPROVED** the closing position of the audit recommendation tracker.

Use of Single Tender Action (STA)

Mark Ross (MR), Assistant Finance Director, presented the report on STAs approved between 30th August and 18th October 2024.

It was reported that one request submitted, in relation to Reagent Rental, was approved during the above reporting period with an annual value of £335,227.13 excluding VAT.

Iwan Jones (IJ), Committee Chair, inquired as to whether this was an expected payment which was not actioned in time resulting in a Single Tender Action being raised.

	Rob Holcombe (RH), Director of Finance and Procurement, confirmed that there were delays which prevented a full tender being requested, however it was agreed that a STA was the best action in the case. Dafydd Vaughan (DV), Independent Member, requested that if there were any delays referenced within the reports it would be helpful to provide detail of the delays to allow further scrutiny. MR, Assistant Finance Director, agreed that additional information will be provided within future reports. Action: Assistant Finance Director The Committee APPROVED the Single Tender Action Report.
ARAC 1211/08	Financial Governance Report and Charges to Financial Capital Procedures (FCP) Mark Ross (MR), Assistant Finance Director, updated the Committee on financial governance, including the approval of two financial control procedures relating to Recovery of Overpayments to Employees and Accounts Payable. It was noted that the two above FCPs requiring approval following amendments were not due for routine review however, had been updated to be brought in line with two new All Wales policies; No Purchase Order (PO) No Pay and NWSSP Recovery of Overpayments to Employees procedure. Rob Holcombe (RH), Director of Finance and Procurement, reinforced that the No PO No Pay Policy was an extremely powerful governance tool for the Health Board in terms of ensuring staff were only ordering appropriate items as well as providing a process to learn lessons from errors made. Iwan Jones (IJ), Committee Chair, asked whether improvements were being seen within shared services in relation to payroll. RH, Director of Finance and Procurement, confirmed that there had been errors made by both the Health Board and Shared Services. On occasion there had been delays and errors in relation to termination forms which resulted in overpayments. A new system was now in place which should improve this over time and result in a reduction of overpayments. The Committee NOTED the contents of the Financial Governance Report and APPROVED changes to the Recovery of Overpayments to Employees and Accounts Payable FCPs.



	ITEMS FOR DISCUSSION
ARAC 1211/09	Report of Losses and Special Payments Mark Ross (MR), Assistant Finance Director, reported on the status of Losses and Special Payments made between the 1st April and 30th September 2024. It was reported that the vast majority of losses related to clinical negligence and personal injury claims which were recovered via the Welsh Risk Pool (WRP), resulting in an actual loss of £1.1million for the Health Board within the above reporting period. The committee was also informed of the estimated potential liability and possible future cost which stood at £190.4million, of which £185.2 was expected to be recoverable from the WRP resulting in a predicted future loss of £5.3million for the Health Board, this figure was similar to that of last year. Iwan Jones (IJ), Committee Chair, asked who internally reviews the cause of the loss and were considerations made to address any issues. Mark Ross (MR), Assistant Finance Director, explained that small items were investigated at a divisional level whereas clinical negligence and personal injury were reviewed via the Patient, Quality Safety and Outcomes Committee and Putting Things Right team to examine the causation of the error. Neil Patrick (NP), Independent Member, inquired as to the role of the Welsh Risk Pool (WRP). Rob Holcombe (RH), Director of Finance and Procurement responded that the WRP acts as an insurance and indemnity cover for NHS Wales for in respect of Clinical Negligence and Personal Injury. Rani Dash (RD), Director of Corporate Governance, informed the committee that at its previous meeting the Board agreed revised delegated limits as well as a change to the formal litigation group where clinical negligence and personal injury claims would have been approved. A report would now be presented to Board in committee at every meeting from November to allow greater oversight. The Committee NOTED the contents of the report for assurance.

Assurance Note on the Implementation of the Actions from the Audit Wales Community Pharmacy Data Matching Report

Jonathan Simms (JS), Clinical Director of Pharmacy, provided the committee with an assurance note on the implementation of actions from the Audit Wales Community Pharmacy Data Matching Report.

It was reported that the main action that had been implemented was the development of a high-cost drugs dashboard which enabled the medicines management team to undertake more detailed audits of high-cost prescribing as well as identifying where these prescriptions were being made.

It was reinforced that there were no specific issues of fraud highlighted within the review and monitoring was the main concern. The dashboard has allowed for a greater oversight as all information was now held centrally.

The Committee **NOTED** the report for assurance.

Update Report on Consultant Job Planning

James Calvert (JC), Medical Director, presented the committee with an update regarding the progress of actions taken to address the 2020 Audit on Consultant Job Planning.

It was reported that a Job Planning Procedure was required which needed to be matched against the all-Wales Consultant Contract 2003. The procedure itself took around three years to produce and obtain the approval required from the BMA. It was noted that ABUHB were the only Health Board in Wales to have a process document that outlines how to implement the contract from 2003.

The implementation of the job planning procedure required an electronic system, which was now live however, it was recognised that the level of job planning compliance was not yet adequate and required significant work to improve. As a result, additional monthly meetings had been implemented to focus specifically on job planning, encouraging a culture change and improving compliance.

Neil Patrick (NP), Independent Member, welcomed the progress that had been made and asked for further detail around the resistance of consultants when implementing the new procedure.

JC confirmed that the majority of consultants understood that they have contractual agreements to plan their workload, however there are a minority of consultants that are reacting adversely to the changes which requires attention from a leadership perspective to encourage positive culture change.

Iwan Jones (IJ), Committee Chair, asked when completion was expected.

JC explained that job plans had an expiration period of one year, therefore it was thought that a compliance rate of 85% of in date job plans would be acceptable once 100% of consultants were on the system. It was anticipated that the position would be at an acceptable level by the end of the financial year.

IJ highlighted that an internal audit of Job Planning was scheduled to take place this year, which may result in a non-positive outcome due to the current position.

JC reassured the committee that structures and processes were now in place which were not available when the previous audit was completed noting that only 1.65% of job plans have not been started.



The Committee requested a plan for completion to be brought back to the next scheduled meeting.

ACTION: Medical Director

The Committee **NOTED** the report and progress made.

ARAC 1211/12

Receive the Private Practice Policy

James Calvert (JC), Medical Director, presented the Committee with an overview of the newly implemented Private Practice Policy which was approved by the Executive Committee on the 3rd October 2024.

The committee was informed that ABUHB was the first Health Board in Wales to hold such a policy. The purpose of the policy was to inform consultants of their contractual obligations and organisational expectations in relation to the undertaking of private practice to clearly outline what specific phrases used within their contract such "your own time" and use of "NHS resource" mean.

Rob Holcombe (RH), Director of Finance and Procurement, acknowledged that the implementation of this policy would have a positive impact on the organisation and help greatly with due diligence and governance.

Neil Patrick (NP), Independent Member, asked whether the British Medical Association (BMA) was supportive of the policy. JC confirmed that the BMA supported the policy, noting that the majority of details within the policy were taken from the BMA website.

Iwan Jones (IJ), Committee Chair highlighted that a key control of the policy was job planning and therefore reinforced the importance of ensuring the job planning process was finalised as soon as possible.

The Committee **RECEIVED** the policy.



ARAC 1211/13

Receive a Mid-Year update in respect of Post-Payment Verification Activity

Amanda Legge (AL), All Wales Post Payment Verification Manager, reported on the mid-year status of PPV activity.

It was reported that in 2024/25 62 visits were scheduled for ABUHB in relation to General Medical Services (GMS), at present 16 of those had been finalised or in progress. The focus will be on outstanding visits and if a revisit is due at the same time an "extended visit" will be conducted, noting that "extended visits" can take up to one month to complete compared to two days for a regular visit. There were 20 scheduled visits for General Ophthalmic Services (GOS) of which 12 had been completed or in progress. The collaborative Working Scheme for General Pharmacy Services (GPS) was now live. There were 42 visits to be completed for GPS of which 14 were in progress.

It was noted that a new pilot was taking place to review invoice price claims as requested by the Health Board.

Rob Holcombe, (RH), Director of Finance and Procurement, acknowledged the ongoing work being completed by the PPV team and noted that from a Health Board perspective recoveries were low.

AL confirmed that ABUHBs recoveries stood at £9,197 from an all Wales £86,000.

The Committed **NOTED** the report for assurance.

ARAC 1211/14

Committee Risk and Assurance Report and Update on implementation of the Risk Management Framework

Rani Dash (RD), Director of Corporate Governance, provided an update on the Health Board's strategic risks, noting that six risks remained outside the Board's risk appetite and were subject to ongoing review with executive leads to determine additional measures to reduce the impact of potential threats.

The committee was informed that, following discussions at the previous committee meeting regarding the need for committees to carry out more focused scrutiny on its risks, reports to individual Committees now focus on one to two priority risks at each meeting, selected based on their level of exposure relative to the agreed threshold.

The committee was informed that there were ongoing discussions taking place with regards to the Once for Wales RLDatix Risk Module and it was anticipated that a more details report to be brought to the committee in the near future.



	It was reported that the Risk Management Framework was continually being promoted and embedded throughout the organisation which had resulted in a growing number of requests received for training. Iwan Jones (IJ), Committee Chair, asked whether current actions in place were suitable to mitigate the risks. RD confirmed that further work was being carried out to improve control of these risks, in order to take a more focused approach to the review of strategic risks. It had been agreed that a deep dive approach toward risks would take place at their respective committees to assess the robustness of mitigations in place. The Committee NOTED the Committee Risk & Assurance Report for Assurance and ongoing work in relation to the RL Datix Module and Risk Management Framework.
ARAC 1211/15	Internal Audit Progress Report Stephen Chaney (SC), Head of Internal Audit, reported on the ongoing internal audit plan for 2024-25, with no concerns raised. It was highlighted that there was a possibility of a timing amendment to the Welsh Intensive Care System audit as a result of funding arrangements not yet being confirmed. Dafydd Vaughan (DV), Independent Member, raised concerns regarding the challenges and national issues of this system and reinforced the need for an audit to be completed as soon as possible to allow lessons to be learnt. The Committee NOTED the Internal Audit Progress Report for Assurance.
ARAC 1211/16	To Receive Internal Audit Reports Stephen Chaney (SC), Head of Internal Audit, with the support of Murray Gard (MR), Senior Auditor, Internal Audit, NWSSP presented the Committee with findings from the audits outlined below. Energy Management – Reasonable Assurance The review focused on rising costs of energy as effective management and control of energy costs had been risk assessed as an area of potential benefit for audit. It was reported that there were positive governance arrangements in place with robust systems operating for data capture and validation. It was noted for information that energy was procured centrally by NWSSP on behalf of NHS Wales as a whole.



NHH Reinforced Autoclaved Aerated Concrete – Reasonable Assurance

The review sought to evaluate the arrangements in place to manage/mitigate the risks associated with the presence of Reinforced Autoclaved Aerated Concrete (RAAC) which had recently been identified as posing a significant risk to the structural integrity of buildings found within Nevil Hall Hospital (NHH).

It was found that detailed and ongoing surveys had been undertaken at Neville Hall with ongoing reporting through the Health Board committee structures.

As a result of the audit a number of recommendations were made, including providing increased assurance surrounding the achievability of the corporate risk registers target score.

Iwan Jones (IJ), Committee Chair, highlighted that recommendations 4 and 5 within the report had not been provided with a numerical date.

Murray Gard (MR), Senior Auditor, Internal Audit, NWSSP, responded that the reasoning for the “future action as necessary” note as opposed to a numerical date was due to the fact that the recommendation could not be implemented at the time of the review. Discussions have taken place with senior management and this will be considered for future projects.

Providing Care to Asylum seekers and Refugees – Reasonable Assurance

The review focused on the arrangements in place within the Health Board for providing care to asylum seekers and refugees, including that applicable guidance was being adhered to.

Neil Patrick (NP), Independent Member, asked if there were any obstacles to success due to the multiplicity of languages that patients may have.

SC confirmed that this would be covered within the training and awareness recommendation for the team as translation service was not something that the team provides at present, however delays caused by translation issues were not deemed to have a major impact on assessments being completed within 14 days.

Newport East Health & Wellbeing centre – Reasonable Assurance

The review focused on the delivery and management arrangements in place to progress the Newport East Health &



	Wellbeing Centre project, and the performance to date against its key delivery objectives. It was reported that the project was operating outside of its time and cost parameters however the delays were not adversely impacting patients and the projected overspend was being managed internally by the Health Board discretionary programme; alongside applying for additional funding via the Welsh Government's integration and rebalancing capital fund. IJ, Committee Chair, raised concerns that the same recommendations appeared to be arising within audits across similar projects as well as a recurrent theme within management responses. These concerns were supported by DV who highlighted the need for these recommendations to be considered and how these lessons could be embedded into future projects. Facilities Stock – Reasonable Assurance Follow up review with a focus on the implementation progress of the Facilities stock recommendations raised within the 2023/24 audit. It was reported that significant work and improvements had been made since the previous audit, however the stock management risk has not yet been fully mitigated. IJ highlighted that part two and three of recommendation one had not been provided with a numerical date for monitoring. SC, confirmed that this should be reviewed at the end of November either closed after option one, if not two or three are to be investigated. SC also noted the new template used for the facilities stock audit and requested any feedback be provided. The Committee NOTED the internal audit reports for Assurance.
ARAC 1211/17	External Audit Progress Report 2024/25 Sara Utley (SA), Audit Wales, presented the Committee with an overview of the 2024/25 External Audit progress report. It was reported that in relation to finance audits the Audit of Charitable Fund Accounts 2023-23 was underway with the Audit of Accounts 2024-25 not yet started. In relation to Performance audit work it was reported that two audits remain in clearance, two remain in draft, one in progress and two at the scoping stage.



Dafydd Vaughan (DV), Independent Member, raised concerns around the delivery of digital services and programmes, particularly at a national level due to substantial issues with a number of systems and reinforced the need for an audit to be completed.

SU confirmed that Audit Wales was aware of these issues and as soon as a scope was available it would be shared with the committee.

The Committee **NOTED** the report for Assurance.

ARAC 1211/18

Final Annual Accounts Memorandum

Julie Rees (JR) Finance Lead, Audit Wales, presented the Committee with an overview of the Final Annual Accounts Memorandum.

It was reported that four recommendations were made within the report, treatment of pooled budget transactions, Existence of fixed assets, senior officer remuneration and ProLease user reviews.

It was noted that one recommendation was only partially accepted by management, in particular disagreeing with part one of the recommendation around scanning in the last quarter. Audit Wales recognised the lack of resource to permit the recommendation and accepted the partial acceptance and management response.

Iwan Jones (IJ), Committee Chair, queried the lack of a numerical implementation date for a recommendation two.

Rob Holcombe (RH), Director of Finance and Procurement, explained that the recommendation remained "ongoing" due to the volume of assets being tagged and feels unable to provide an exact date of completion and agreed to provide a progress update to the next committee. **ACTION: Director of Finance and Procurement**

Kelly Jones (KJ), Head of Capital Finance, informed the committee that 81% of assets were tagged, with approximately 1000 items left to complete. It was anticipated that walk arounds would be completed on the three main hospital sites within the last quarter. Upon completion of historical asset tagging more regular scanning will be implemented.



	The Committee NOTED the report for Assurance.
	Items for Information
ARAC 1211/19	Committee Programme of Business Rani Dash (RD), Director of Corporate Governance, presented the Committee Forward Work Programme noting that committee business was on track. The Committee NOTED the Committee Programme of Business for Assurance.
	Other Matters
ARAC 1209/22	Items to be Brought to the Attention of the Board and Other Committees • No items raised
ARAC 1209/23	Any Other Urgent Business • Nothing reported.
ARAC 1209/24	Date of the next meeting • Tuesday 18th February 2025

DRAFT

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
September 2024	ARAC 1209/10 Mid-year Report on the delivery of the Clinical Audit Plan	Create and share a document with the Medical Director's Office outlining the reporting schedules and focus of reports for the Audit Risk and Assurance and Patient Quality, Safety and Outcomes Committee.	Head of Corporate Risk and Assurance	12 October 2024	Completed Circulated via email.  Purpose of Reporting the Annu
September 2024	ARAC 1209/13 Implementation of the Governance Priorities set out within the IMTP 2022-25	The Committee to receive an update on the Health Board's decision and progress regarding a suitable electronic risk management system.	Head of Corporate Risk and Assurance	January 2025	Completed Updated provided within the risk progress report presented to the committee in November 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
November 2024	ARAC 1211/04 Minutes of the previous meeting.	The committee to receive an additional detailed report on the delivery of the Clinical Audit plan to provide assurance.	Secretariat/Assistant Director Quality and Patient Safety	February 2025	Completed Included within February agenda – item 1.5
November 2024	ARAC 1211/06 Audit Recommendations Tracker	The committee to receive a review of all recommendations from the Discharge Planning 2022 internal audit	Secretariat/Director of Corporate Governance and Director of Nursing	February 2025	Completed Included within February agenda – item 3.7 c
November 2024	ARAC 1211/07 Use of Single Tender Action (STA)	Additional information on delays to be incorporated within future reports.	Assistant Finance Director	February 2025	Completed Information to be incorporated to all future reports as required.



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.

Aneurin Bevan University Health Board

Health Board Committee Assurance Note

Item	Job Planning Progress Update
Date scheduled on Action Log	Quarter 4 -February 2025
Executive Lead	Dr James Calvert, Medical Director
Reporting to:	Audit, Risk & Assurance (ARA) Committee

Summary

This assurance note provides an interim update on the implementation of Consultant Job Planning in the following areas:

- Implementation and roll-out of an electronic job planning system including plan of completion.
- Job planning compliance.

A Paper on Job Planning and compliance with audit recommendations was received by the ARA Committee in November 2024. The committee requested a plan for completion of the roll out of Electronic Job Planning to be provided to the February meeting.

Electronic Job Planning system

The L2P job planning system has been configured to the Amendment to the Consultant Contract (Wales (2003)) and the Health Board's Job Planning Procedure. Training sessions on the system continue to be delivered.

Rollout of L2P e- Job Planning

As part of the IMTP planning framework released in November 2024 the Welsh Government, via the Cabinet Secretary, identified enabling actions for IMTPs in Wales. These include "to ensure effective implementation of job planning policy, to include ensuring that > 90% of all Consultants have an agreed job plan in place at all times by 30 September 2025". The Health Board's People Plan has been updated to include this target and associated action to achieve it.

The reasons for delay in roll out and corresponding poor Job planning compliance have previously been identified to the ARAC. Since the committee meeting in November 2024 further actions have been taken to identify a completion plan and support the delivery of this and the 90% Welsh Government target.

Action to support the completion plan include: -

- Additional members of the E-Systems team are focusing on the roll out. Previously the support from the central Medical E-Systems team was prioritised to those areas first on the rostering implementation plan. This was agreed to reduce delays from a rostering implementation perspective. However, this approach has been revised to ensure that all the Medical E-Systems staff are focused on the roll out of job planning and achieving 90% completion by September 2025.
- The team has also been aligned to those areas requiring additional support in using the new system.
- Additional training sessions are being conducted and targeted bespoke training where needed.
- Drop-in workshops will be conducted by L2P in early Spring 2025
- The trajectory for completion across each division (appendix one) has been revised to meet the 90% target by September 2025. This is currently with the senior divisional management teams for approval. Progress against this will be reported to the monthly Medical Leaders meeting.
- Monthly compliance reports continue to be provided to the Divisional management teams
- The Deputy Medical Director has asked Divisional Directors to remind Consultants to utilise their core SPA time to undertake Job Planning.

Job Planning Compliance

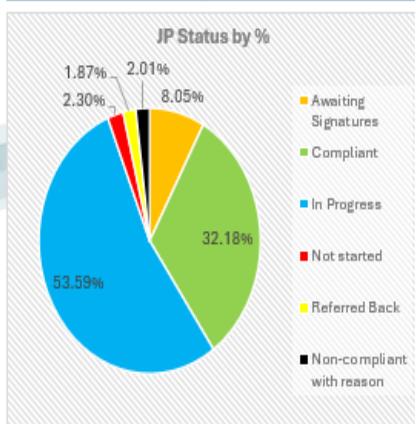
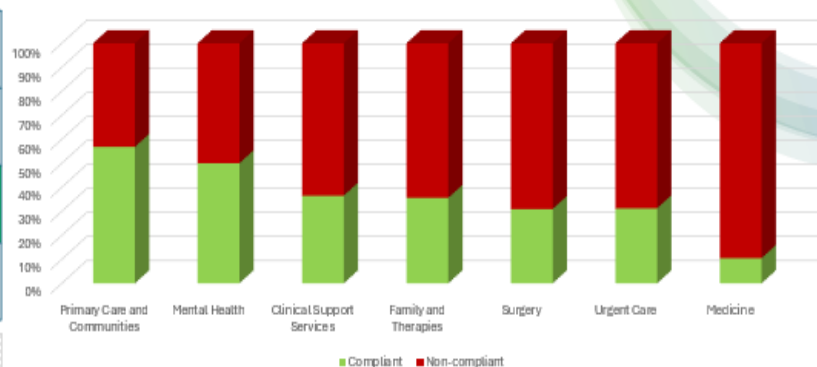
As of 31st January 2025, consultant job planning compliance is 33.54% across the Health Board. This is an increase of 6% in the last two months.

In addition to those consultants with an in-date job plan there are 50 i.e. 9.09% within the system simply awaiting final sign off and 266 i.e. 48.36% job plans in progress within the system.



Health Board Job Plan Compliance + Status by Division

Total count	696
Total Job Plans Completed (In-date L2P and/or Uploaded)	224
Total compliance	32.18%
Difference from November	+ 5.25%



Category	Job plans included in category	Number of job plans in category	% of total
Compliant job plans	Complete	216	31.03%
	Uploaded	8	1.15%
Category	Job plans included in category	Number of job plans in category	% of total
Non-compliant job plans	Referred back	13	1.87%
	Awaiting signatures	56	8.05%
	In progress	373	53.59%
	Not started	16	2.30%
	Non-compliant with reason	14	2.01%
Grand Total		696	100%

Summary

Achievement of 85% compliance with consultant job planning has been amended to 95% to reflect the new Welsh Government target. A plan to deliver this has been agreed and will be monitored on a monthly basis with Divisional Directors.

Once all job plans have been completed on the L2P system the anticipation is that future rounds of job planning will be easier thus improving both compliance and quality of the resulting job plan.

Divisional/Directorate Job Plan Compliance 90% Target Trajectory from January 2025 up to 31 July 2025

	Consultant		SAS	
Division/Directorate	Monthly Target		Monthly Target	Overall Target Total per Month
Obs and Gynae	2		1	3
Paediatrics	3		1	4
Community Paediatrics	1		1	2
Neonates	1		1	2
Sexual Health	0		1	1
CAMHS	2		0	2
Family & Therapies	9		5	14
General Adult Psychiatry	2		1	3
Learning Disabilities	1		0	1
Older Adult Psychiatry	1		1	2
Mental Health	4		2	6
Acute Med	1		1	2
Cardiology	2		0	2
COTE	3		1	4
COTE YYF	1		1	2
Endo Diabetes	2		1	3
Gastro	2		0	2
Neurology	2		0	2
Nephrology	1		0	1
Respiratory	2		0	2
Stroke	1		1	2
Medicine	17		5	22
Community COTE	0		1	1
Dental	1		0	1
Frailty	1		1	2
Palliative Care	1		1	2
Primary Care & Community	3		3	6
PACCT - Anaesthetics	9		3	12
PACCT - Critical Care	1		1	2
PACCT - Pain	1		0	1
Pathology	2		1	3
Radiology	2		1	3
Clinical Support Services	15		6	21
Dermatology	1		1	2
ENT	2		1	3
General Surgery	2		1	3
Haematology	1		0	1
Ophthalmology	2		1	3
Oral Surgery	2		1	3
Rheumatology	1		0	1
T&O	5		2	7
Urology	0		0	0
Surgery	16		7	23
Emergency Medicine	3		1	4
Urgent Care	3		1	4
Total	67		29	96



Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	18 February 2025
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Delivery of the Clinical Audit Plan
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Dr James Calvert, Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Leeanne Lewis, Assistant Director for Quality & Patient Safety Joanne Stimpson, Quality and Patient Safety Lead for National Clinical Audit

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

Aneurin Bevan University Health Board is dedicated to providing safe and effective care. Clinical audit (CA) is one of the approaches used to provide quality assurance of care. CA measures the extent to which services meet standards of care set out in local or national guidelines. Improvements identified as being necessary following completion of an audit are incorporated into SMART action plans, reviewed by leadership teams, and approved by the Clinical Effectiveness Group. National Audit results are discussed at PQSOC meetings as part of the standing agenda.

The National Clinical Audit Outcome Review Programme (NCAORP) allows benchmarking against other UK healthcare providers. The Health Board adheres to NCAORP timelines and ensures communication between the Clinical Audit Team and Clinical Leads for timely action plans. Audit results are part of the Health Board's quality system, combined with other data sources to identify and promote good practices and areas for improvement.

The Health Board uses the AMaT system to track audit recommendations, service assurance levels, risk levels, and to store and monitor SMART action plans



Cefndir / Background

The National Clinical Audit and Outcome Review Plan (NCAORP), published annually by Welsh Government, is part of the process for assuring the quality and safety of healthcare across Wales. All healthcare organisations must participate in the listed national audit projects. ABUHB’s audit plan aligns with NCAORP.

Following an Internal Audit report in November 2022, the CA Team has focused on implementing the Health Board’s Clinical Audit Strategy. This includes engaging with Divisions, standardising audit report templates, and improving action plan scrutiny. The web-based Audit Management and Tracking System (AMaT) has been implemented to track audit results and develop action plans.

Local audit plans, supplementing NCAORP audits, are developed by Directorates and are also recorded in AMaT. The system helps build audit proformas, captures data, produces a summary of results, and allows recording of action plans, meeting many internal audit recommendations.

CA reporting is supported by a robust structure, with Executive Leadership delegated to the Medical Director. Assurance is provided through reporting to the Patient Quality and Safety Outcomes Committee (PQSOC), which scrutinises National Clinical Audit performance and monitors improvement plans.

CA is key to fulfilling the Duty of Quality, supporting a sustainable and resilient health and care system.

Asesiad / Assessment

The Health Board has a defined process for scrutinising National Clinical Audit Reports. These are presented to the Clinical Standards and Effectiveness Group (CSEG) following publication. Clinical Leads are notified of report due dates and provided with locally developed, standardised proformas, on which to present local performance against national benchmarks. Improvement plans aligned with national recommendations are developed and tracked via the Audit Management and Tracking (AMaT) system.

The 2024/25 Annual Clinical Audit Plan, approved by the Patient Quality and Safety Outcomes Committee (PQSOC) in April 2024, has been implemented over the course of the year. Between April 2024 and January 2025, 48 audits were published, with 16 reports presented to CSEG. The remaining audits are scheduled for review in early 2025.

The report highlights audits that the Health Board did not participate in (16) and the reasons for non-participation (given below):



- NHS England data only (8).
- The Health Board has not participated in all aspects of the National Respiratory Audit Programme (NRAP). This year we did not audit COPD, and Adult Asthma or participate in the Organisational Audit (3). We did however participate in the Primary Care and Paeds Asthma audits which have been presented to CSEG as part of the NCAORP. This is due to the Directorate not being able to accommodate the data acquisition function within its resource at this point. The Medical Director has indicated to the division that participation is mandatory, and resource needs to be found from within the Division or Directorate.
- Dashboard presented (1) for National Pregnancy in Diabetes (NPID). A new dashboard was made available for the NPID audit. The original report refers to data published in October 2023 and was previously presented at CSEG in November 2023. There was no updated report or additional recommendations.
- Paediatric Intensive Care Audit Network (PICANet) – UHW only (1).
- The QPS Clinical Audit Team are linking with the National Confidential Enquiry into Patient Outcome for the audit – 'Death on Planning for the End' - review of the quality of care provided to adult patients. This will assess if data has been inputted by teams. (1).
- National Paediatric Diabetes Audit (NPDA) has released a first year of care Parent and Patient reported experience measures (PREM). Currently there is no local data. National data will be added to the audits results in March and presented in May CSEG (1).
- The annual report on inpatient falls will be picked up with the appropriate Clinical Lead to ensure there is discussion of the report in the Falls Group (1).

AMaT has been widely adopted across the Health Board, with 2,197 registered users actively conducting and reporting audits. Ongoing training supports professional development and revalidation requirements. The system tracks 232 ongoing and 65 completed audits, with assurance levels recorded and aligned with the Health Board's risk management framework. While most audits demonstrated minor or significant assurance, action tracking revealed that 30% of actions remain overdue. There were no audits recorded as having catastrophic or very limited assurance.

An Internal Audit report (November 2022) identified resource challenges within the clinical audit infrastructure. The Medical Director's team are not resourced to review the actions from local audits. These are managed by the Directorates/ Divisions. To address this, a resource mapping exercise is proposed to enhance data acquisition and audit participation. Additionally, escalation mechanisms are being developed to ensure the Divisional Triumvirates are aware of audit non-participation, unaddressed risks, and improvement actions overdue.



Key priorities moving forward include reducing overdue actions, triangulating audit results to inform planning, and ensuring effective feedback of audit learning to clinical teams. These steps will strengthen the Health Board's commitment to delivering high-quality, patient-centred care through continuous improvement.

Further details on audit outcomes, activities, and strategic improvements are provided in the Appendix, ensuring transparency and accountability to the Audit, Risk, and Assurance Committee.

Argymhelliad / Recommendation

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

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

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

Gwybodaeth Ychwanegol:



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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives



National Clinical Audit Programme Aneurin Bevan University Health Board

Delivery of the Clinical Audit Plan
April 2024 to January 2025

National Clinical Audit Outcome Review Plan (NCAORP)

Aneurin Bevan University Health Board achievements for 2024/2025

NCAORP 2024/2025	
	Number of audits
NCAORP 2024/2025	48
Published Apr 24 - Jan 25	41
Published Feb – March 2025	7
	48
Presented at CSEG to date (end of Jan 2025)	16
Arranged for future CSEG (Feb and March)	15
CSEG after year end (May CSEG 2025/2026)	1
NHS England (not applicable)	8
ABUHB Non-participation	8
	48
Presented at CSEG (April 2024 to Jan 2025)	33%
Arranged for future CSEG (Feb and March 2025)	31%
CSEG after year end (May CSEG 2025/2026)	2%
NHS England (not applicable)	17%
ABUHB Non-participation	17%
	100%

Assurance and Risk Levels:

Of the 16 reports that have been presented to CSEG from April 2025 to Jan 2025:

Assurance		Risk	
Full	6%	None	6%
None	0%	Minor	56%
Significant	56%	Moderate	25%
Limited	38%	Major	13%
Very Limited	0%	Catastrophic	0%
	100%		100%

More information on non participation of audits and information on risks are included in the following slides:

Audit non participation

- Total of non participation is 16. Reasons are:
- NHS England data only (8).
- The Health Board has not participated in all aspects of the National Respiratory Audit Programme (NRAP). This year we did not audit COPD, and Adult Asthma or participate in the Organisational Audit (3). We did however participate in the Primary Care and Paeds Asthma audits which have been presented to CSEG as part of the NCAORP. This is due to the Directorate not being able to accommodate the data acquisition function within its resource at this point. The Medical Director has indicated to the division that participation is mandatory and resource needs to be found from within the Division or Directorate.
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- The annual report on inpatient falls will be picked up with the appropriate Clinical Lead to ensure there is discussion of the report in the Falls Group (1).

CSEG Date	Audit title	Assurance	Risk	Update
May-24	National Lung Cancer Audit State of the Nation report (01/01-31/12/2022 data; Eng & Wales)	Significant	Minor	All report recommednations have been achieved. Actions are fully completed by Clinical Lead.
May-24	National Audit of Dementia - Care in General Hospitals 2022-2023 Round 5 Audit Report	Limited	Major	The remains a large area of work for the Health Board and the Clinical Lead is engaging with site leads and support staff across the Health Board to improve services for patients with Dementia and Delirium. The service has overdue actions.
May-24	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)	Limited	Major	Two of the three actions are fully complete. One action is partially complete (overdue) which relates to staffing resources issues across the service. Over the period of 5 years the total annual cost for ABUHB FLS including staff cost, overhead charge of 15% and prescribing costs be approx. £450,376 to £883,488. The annual benefits across acute care is equal to £1439,436 and all benefits inclusive of community and social care will be 2.1 Million.
Jul-24	National Diabetes Foot Care Audit (NDFA) State of the Nation report, 01/04/2021-31/03/2022 TBC; Eng & Wal.	Significant	Minor	Continous QI work being undertaken to further progress patient care. All report recommendations being achieved.
Sep-24	National Respiratory Audit State of the Nation report - PAEDIATRIC ASTHMA	Significant	Minor	One action has been completed, however meetings to discuss the joint pathways with Primary Care and Adult Serivces are yet to be organised.
Sep-24	NCEPOD - Endometriosis	Significant	Moderate	There is a comprehensive action plan in place which is to be completed by 31st March 2025.
Sep-24	MBRACCE-UK Perinatal mortality surveillance July 2024 - State of the nation report	Significant	Minor	All recommendations have been achieved.
Nov-24	National Emergency Laparotomy Audit State of Nation report 2024	Significant	Minor	Presented to CSEG in November 2024 and actions relating to COTE consultant expansion and patient level data entry - both to be resolved by 2026.
4/15				33/415

CSEG Date	Audit title	Assurance	Risk	Update
Nov-24	National Ovarian Cancer Audit (NOCA) - State of the Nation	Limited	Minor	A new audit to NATCAN and ongoing actions throughout 2025. This audit is further advanced in Engalnd, therefore expectations are there will be improved data for Wales moving forward.
Nov-24	National Neonatal Audit Programme 2024 report	Significant	Minor	The metrics within the audit are improving year on year and are contiously monitored using the NNAP Dashboard.
Nov-24	National Primary Breast Cancer Audit (NaoPri) - State of the Nation	Significant	Minor	Two recommendations have been completed within the Health Board and three actions are palnned to be completed during 2025.
Nov-24	National Metastatic Breast Cancer Audit (NaoMe) - State of the Nation	Limited	Moderate	Three actions are to be completed during 2025.
Jan-25	National Hip Fracture Database (NHFD)	Limited	Moderate	Presented to CSEG in January 2025 and three actions are to be completed during 2025.
Jan-25	Epilepsy12 State of the National report, England and Wales (2021-23)	Significant	Minor	Business case submitted to improve EEG waiting times in Neurophysiology. Ongoing discussions across the team to improve services.
Jan-25	National Early Inflammatory Arthritis Audit State of the Nation 2024 Annual Report	Full	None	All report recommendations are in place and the service has improved from previous outlier status.
Jan-25	National Pregnancy in Diabetes (NPID) Annual Data Only Release and Dashboard Update (2023; Eng Only)	Significant	Minor	No recommendations were provided as this was dashboard release only.
Jan-25	National Respiratory Audit Programme Primary Care Report (cohort TBC)	Limited	Moderate	Presented to CSEG in January 2025 ther eis an extensive action plan of which some recommendations have been fully completed and other ations are to be completed during 2025.
5/15				34/415

National Clinical Audit Outcome review Plan 2024/2025

PROJECT NAME	FULL REPORT TITLE	PUBLICATION DATE	CSEG (presented or future date)	Comments
NLCA - National Lung Cancer Audit	National Lung Cancer Audit State of the Nation Report 2024	10/04/2024	May-24	Complete on AMaT
NDA - National Diabetes Audit	National Diabetes Foot Care Audit 2018 to 2023	09/05/2024	Jul-24	Complete on AMaT
NPDA - National Paediatric Diabetes Audit	National Paediatric Diabetes Audit report on care processes and outcomes 2022/23	10/04/2024	Jul-24	Complete on AMaT
Medical and Surgical Clinical Outcome Review Programme	Endometriosis: A Long and Painful Road	11/07/2024	Sep-24	Complete on AMaT
NRAP - National Respiratory Audit Programme	Breathing well: An assessment of respiratory care in England and Wales	11/07/2024	Sep-24	Presented -Paeds Only Complete on AMaT
MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal Mortality Surveillance: State of the Nation Report	11/07/2024	Sep-24	Complete on AMaT
NELA - National Emergency Laparotomy Audit	Ninth Patient Report of the National Emergency Laparotomy Audit	10/10/2024	Nov-24	Complete on AMaT
NNAP - National Neonatal Audit Programme	National Neonatal Audit Programme (NNAP) - Summary report on 2023 data	10/10/2024	Nov-24	Complete on AMaT
NOCA - National Ovarian Cancer Audit	National Ovarian Cancer Audit State of the Nation Report 2024	12/09/2024	Nov-24	Complete on AMaT
NAoMe - National Metastatic Breast Cancer Audit	National Audit of Metastatic Breast Cancer State of the Nation Report 2024	12/09/2024	Nov-24	Complete on AMaT

PROJECT NAME	FULL REPORT TITLE	PUBLICATION DATE	CSEG (presented or future date)	Comments
NAoPri - National Primary Breast Cancer Audit	National Audit of Primary Breast Cancer State of the Nation Report 2024	12/09/2024	Nov-24	Complete on AMaT
NEIAA - National Early Inflammatory Arthritis Audit	State of the Nation Summary Report 2024	10/10/2024	Jan-25	Complete on AMaT
FFFAP - Falls and Fragility Fracture Audit Programme	National Hip Fracture Database Annual Report 2024 A broken hip - three steps to recovery	12/09/2024	Jan-25	Complete on AMaT
NRAP - National Respiratory Audit Programme	Wales primary care clinical audit report	12/09/2024	Jan-25	Complete on AMaT
Ep12 - National Audit of Seizures and Epilepsies	Epilepsy12 2024 combined organisational and clinical audits	11/07/2024	Jan-25	Scheduled
FFFAP - Falls and Fragility Fracture Audit Programme	Fracture Liaison Service Database Annual Report - You've had a fracture; how can we prevent another?	09/01/2025	Feb-25	Scheduled
NBoCA - National Bowel Cancer Audit	National Bowel Cancer Audit State of the Nation Report	09/01/2025	Feb-25	Scheduled
NPCA - National Prostate Cancer Audit	National Prostate Cancer Audit State of the Nation Report	09/01/2025	Feb-25	Scheduled
NOGCA - National Oesophago-Gastric Cancer Audit	National Oesophago-Gastric Cancer Audit State of the Nation Report	09/01/2025	Feb-25	Scheduled

Project Name	Full Report Title	Publication Date	CSEG (presented or future date)	Comments
NAD - National Audit of Dementia	Care in General Hospitals 2023-24: Round 6 Audit Report	12/12/2024	Feb-25	Scheduled
NVR - National Vascular Registry	State of the Nation Report 2024	14/11/2024	Feb-25	Scheduled
NKCA - National Kidney Cancer Audit	National Kidney Cancer Audit State of the Nation Report 2024	12/09/2024	Feb-25	Scheduled
NNHLA - National Non-Hodgkin Lymphoma Audit	National Non-Hodgkin Lymphoma Audit State of the Nation Report 2024	12/09/2024	Feb-25	Scheduled
NPaCA - National Pancreatic Cancer Audit	National Pancreatic Cancer Audit State of the Nation Report 2024	12/09/2024	Feb-25	Scheduled
MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal Mortality Data Only Release - 2023	13/02/2025	Mar-25	Scheduled
NCAP - National Clinical Audit of Psychosis	State of the Nation report (Bespoke data)	13/02/2025	Mar-25	Scheduled
NCISH - Mental Health Clinical Outcome Review Programme	Mental Health Clinical Outcome Review Programme Annual Report 2025	13/02/2025	Mar-25	Scheduled
Child Health Clinical Outcome Review Programme	Juvenile Idiopathic Arthritis report	13/02/2025	Mar-25	Scheduled
MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal Confidential Enquiry - State of the Nation Report: The care of recent migrant women with language barriers who have experienced a stillbirth or neonatal death	12/12/2024	Mar-25	Scheduled

Project Name	Full Report Title	Publication Date	CSEG (presented or future date)	Comments
SSNAP - Sentinel Stroke National Audit Programme	State of the Nation Report 2024	14/11/2024	Mar-25	Scheduled
NPDA - National Paediatric Diabetes Audit	Annual Core State of the Nation Report (Year 3)	13/03/2025	May-25	Scheduled CSEG 2025/2026
PICANet - Paediatric Intensive Care Audit	National Paediatric Critical Care Audit State of the Nation Report 2024	12/12/2024	Childrens Hospital for Wales - UHW	Children's Hospital for Wales - UHW
NPDA - National Paediatric Diabetes Audit	Quarterly Dashboard Update Q3	17/02/2025	Dashboard update	No report - updating at CSEG
NATCAN - National Cancer Audit Collaborating Centre	Prostate Cancer quarterly data only release (England only) - performance indicator update and new dashboard	13/02/2025	England	Not applicable
NCMD - National Child Mortality Database	Child deaths due to Asthma or Anaphylaxis National Child Mortality Database Programme Thematic Report	12/12/2024	England	Not applicable
NCMD - National Child Mortality Database	Child Death Review Data Release: Year ending 31 March 2024	14/11/2024	England	Not applicable
NCMD - National Child Mortality Database	Learning from deaths: Children with a learning disability and autistic children	11/07/2024	England	Not applicable
NMPA - National Maternity and Perinatal Audit	Evaluating hospital and crisis care for perinatal mental health	11/07/2024	England	Not applicable
FFFAP - Falls and Fragility Fracture Audit Programme	The 2024 National Audit of Inpatient Falls (NAIF) report on 2023 clinical data	10/10/2024	Inpatient falls steering group	Discussion with Clinical Lead for actions

PROJECT NAME	FULL REPORT TITLE	PUBLICATION DATE	CSEG (presented or future date)	Comments
Medical and Surgical Clinical Outcome Review Programme	Planning for the End- A review of the quality of care provided to adult patients towards the end of life	14/11/2024	NCEPOD no local data - requested	Not applicable
NRAP - National Respiratory Audit Programme - Adult Asthma	Breathing well: An assessment of respiratory care in England and Wales	11/07/2024	not participating	Discussed with directorate
NRAP - National Respiratory Audit Programme - COPD	Breathing well: An assessment of respiratory care in England and Wales	11/07/2024	not participating	Discussed with directorate
NRAP - National Respiratory Audit Programme	Organisational Audit 2024	14/11/2024	Not participating in COPD/Adult Asthma	CL in discussion with Respiratory lead for Wales
NPDA - National Paediatric Diabetes Audit	First Year of Care Parent and Patient Reported Experience Measures (PREMs) 2024	14/11/2024	PREMS Only	Awaiting outcome
CVDPREVENT- Cardiovascular Disease Prevention Audit	Fourth Annual Report	12/12/2024	Medical Director QPS looking at report	Awaiting outcome
MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Saving Lives, Improving Mothers' Care - State of the Nation Report	10/10/2024	Medical Director QPS looking at report	Awaiting outcome
CVDPREVENT- Cardiovascular Disease Prevention Audit	Deep Dive: inequalities in cholesterol management by sex for patients with CVD	11/07/2024	Medical Director QPS looking at report	Awaiting outcome
NAD - National Audit of Dementia	National Audit of Dementia - Spotlight Audit in Memory Assessment Services Report 2023/24	08/08/2024	Spotlight report	Awaiting outcome

Total Number of actions presented to from CSEG	
Number fully completed	13
Number partially completed	7
Number ongoing	29
Number overdue	21
	70

% fully completed	19%
% partially complete	10%
% ongoing	41%
% overdue	30%
	100%

Those fully completed were completed within 12 months.
However, only 7% (5 of 70) were completed within the stated timeframe
All overdue actions are being highlighted to the Clinical Leads and the Divisional triumvirates.

ACTIONS

A SMART action plan is completed on AMaT based upon the report recommendations and/or the Clinical Leads local recommendations.

Some of the report recommendations may already be achieved within the Health Board – these are noted as already achieved.

Ongoing actions may be actions that take a longer time to put in place or could have had a shorter deadline which has then been extended.

All actions for National Clinical Audits are monitored by the Medical Director’s Clinical Audit QPS team and chased with the relevant nominated responsible person and are updated accordingly in AMaT.

Use of Audit Management and Tracking (AMaT) System

April 2024- January 2025

Aneurin University Health Board has 2197 users registered on AMaT

(This includes 51 medical students in training)



Clinical Audit Area:

- 232 active audits – ongoing
- 65 closed audits – closed as completed

Clinical Area Actions:

• 273 actions within Clinical Area

❖ 174 in audits as part of the NCAORP

- 88 Fully complete
- 6 Partially complete
- 50 Overdue
- 30 ongoing
- 8 Unable to complete/no longer relevant

All actions within the audits that form the NCAOPR are monitored by the Medical Director's Clinical Audit QPS team.

❖ 99 actions in local audits

- 75 Fully complete
- 8 Partially complete
- 9 Overdue
- 4 ongoing
- 3 Unable to complete/no longer relevant

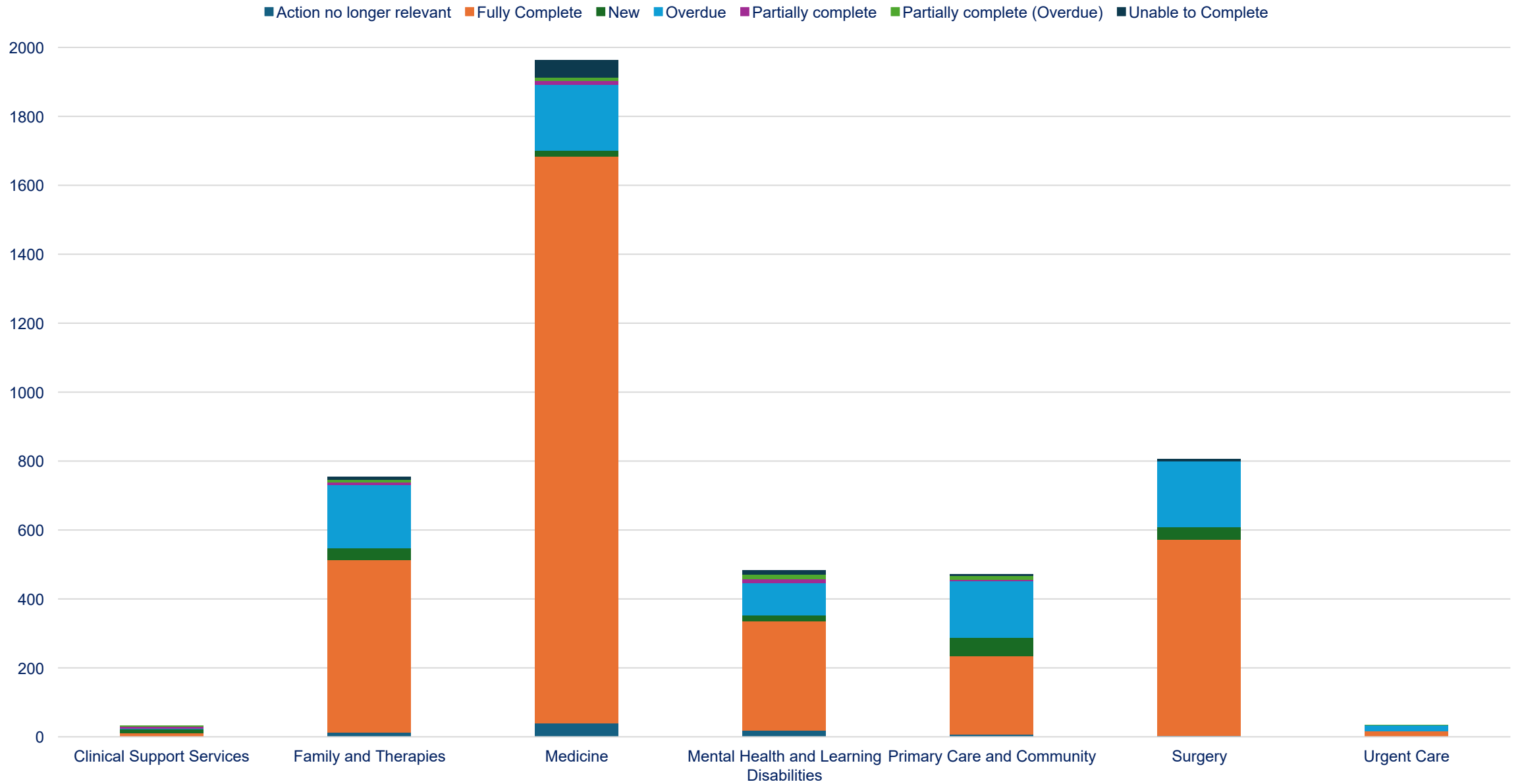
Actions for local audits sit within the Directorates / Divisions. The QPS infrastructure is limited to undertake audit management of local audits.

Ward Area – Total 173 audits registered with 4548 actions, see below by Division:

Row Labels	Action no longer relevant	Fully Complete	New	Overdue	Partially complete	Partially complete (Overdue)	Unable to Complete	Grand Total
Clinical Support Services		10	13	2	6	2		33
Family and Therapies	12	501	33	185	8	7	9	755
Medicine	38	1646	17	190	12	9	51	1963
Mental Health and Learning Disabilities	17	317	19	92	13	14	12	484
Primary Care and Community	6	228	54	164	3	11	5	471
Surgery	3	569	36	191	1		7	807
Urgent Care		16		18		1		35
Grand Total	76	3287	172	842	43	44	84	4548

- These actions are across 17 Aneurin Beavan University Health Board sites
- 3594 actions recorded evidence
- RAG Ratings:
 - Red - 83 (This is a critical action that must be completed promptly)
 - Amber - 675 (This is an important action that must be completed by the due date)
 - Green - 3790 (This action should be completed by the due date)
- Actions have been allocated to 281 members of staff

Actions by Division



DYDDIAD Y CYFARFOD: DATE OF MEETING:	18 February 2025
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Audit, Risk and Assurance Committee Work Plan 2025/26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Director of Corporate Governance

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 aligned to Guidance set out in the 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 2025)
- Seek assurance and provide scrutiny on behalf of the Board, in relation to the delivery of 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 of 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 Committee is requested to approve the adjustment of the Audit Recommendation Tracker's reporting frequency to align with end-of-quarter reporting. As outlined in the table below, the report will be presented at the first scheduled Committee meeting following the close of each quarter.

This change aims to enhance the quality of reporting while reducing the number of update requests made to Executives. Additionally, the Committee previously agreed that reporting frequency could be reduced once substantial improvements had been made to legacy recommendations. The Audit Tracking Report presented to the Committee provides assurance that these improvements have been achieved. Aligning with quarterly reporting will help ensure more comprehensive updates while maintaining effective oversight.

Quarter	Time Period	Committee to receive the report
Q1	April 25 – June 2025	4 th September 2025
Q2	July 25– September 2025	21 st October 2025
Q3	October 25 – December 2025	12 th February 2026
Q4	January 26 – March 2026	TBC April 2026

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

Argymhelliad / Recommendation

The Committee is requested to:

- **RECEIVE** and **APPROVE** the proposed Committee work plan and **NOTE** that it will be brought forward to each 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):	Choose an item. Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	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:	
• 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 2025/26

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 2024 and the Structured Assessment 2024 recommendations
- The Board's Assurance Framework and Corporate Risk Register; and
- Key statutory, national, and best practice requirements and reporting arrangements.

Area of Focus as per Standing Orders:

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

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

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

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

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2025/26						
			Quarter 1			Quarter 2	Quarter 3		Quarter 4
			22 nd April 2025	20 th May Draft Accounts	24 th June Final Accounts	4 th Sept 2025	21 st Oct 2025	16 th Dec 2025	12 th Feb 2026
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 2025/26	An	Chair & DofCG	√						√
Review of Committee Programme of Business	SI	Chair		√	√	√	√	√	
Annual Review of Committee Effectiveness 2024/25 to include a review of the Terms of Reference	An	Chair & DofCG	√						
Committee Annual Report 204/25	An	Chair & DofCG			√				
Corporate Governance, Risk & Assurance									
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	Qu	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	√		√	√	√	√	

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2025/26						
			Quarter 1			Quarter 2	Quarter 3		Quarter 4
			22 nd April 2025	20 th May Draft Accounts	24 th June Final Accounts	4 th Sept 2025	21 st Oct 2025	16 th Dec 2025	12 th Feb 2026
Financial Governance and Control									
Report of the use of Single Tender Action	SI	DofF&P	√			√	√	√	
Report of Losses and Special Payments <i>(May report will be included in the Accounts)</i>	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 <i>(Feb 2026)</i>	3-Yearly	DofF&P	-	-	-	-	-	-	-
Receive the Counter Fraud Annual Report	An	HofCF		√					
Agree the Counter Fraud Annual Workplan	An	HofCF	√						

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2025/26						
			Quarter 1			Quarter 2	Quarter 3		Quarter 4
			22 nd April 2025	20 th May Draft Accounts	24 th June Final Accounts	4 th Sept 2025	21 st Oct 2025	16 th Dec 2025	12 th Feb 2026
Receive a Quarterly Report on Counter Fraud Activity	Quarterly	HofCF				√		√	
Agree the Counter Fraud Functional Standard Return Declaration	An	HofCF			√				
Receive the Post Payment Verification Annual Report, including, the Annual Workplan for 2025-26	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 2024 - 2025	An	Medical Director			√				
Agree the Clinical Audit Plan 2025 - 2026	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		√					
Receive the draft external auditor's opinion on the quality account	An	AW						√	
Receive the 2025 Structured Assessment	An	AW					√		
Receive External Audit Progress Report 2025-26	SI	AW	√	√	√	√	√	√	√

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2025/26						
			Quarter 1			Quarter 2	Quarter 3		Quarter 4
			22 nd April 2025	20 th May Draft Accounts	24 th June Final Accounts	4 th Sept 2025	21 st Oct 2025	16 th Dec 2025	12 th Feb 2026
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							
Total Items Scheduled (excluding preliminary items) -to be updated prior to each meeting			13	13	17	12	16	14	8
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
√R	Received at the Scheduled meeting
D	Deferred from this agenda
√ D	Deferred Scheduled agenda item Received
W	Withdrawn from FWP
T	Transferred to another Committee

IC	Matter discussed In Committee

DRAFT

DYDDIAD Y CYFARFOD: DATE OF MEETING:	18 February 2025
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Internal and External Audit Recommendation Tracker
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Corporate Risk and Assurance

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

ADRODDIAD SCAA SBAR REPORT <u>Sefyllfa / Situation</u> This report provides the Audit Risk and Assurance Committee (the Committee) with a comprehensive overview of the current status of all identified internal and external audit recommendations as of 30 December 2024. The report also updates the Committee on the progress made since the last reporting period, highlighting recommendations with revised deadlines, those that remain outstanding, and those where management action plans have been fully implemented. <u>Cefndir / Background</u> As of the end of the last reporting period on 30 September 2024, the following was noted: 17 recommendations were completed. 22 recommendations had their timeframes revised. 3 internal and external recommendations remained overdue. From 01 October to 31 December 2024: - An additional 63 recommendations became overdue. 88 updates were requested for overdue recommendations within this period.

Asesiad / Assessment

Internal and External Audit Recommendation Tracking

The master tracker has been updated to include all Internal and External Audit Recommendations up to the last Committee meeting on 12 November 2024. This tracker includes a total of **137** recommendations across **43** audits, though only those overdue by **31 December 2024** are detailed in this report.

As stated, a total of **88** recommendations required an update on progress. Table 1 provides the Committee with a breakdown of the **88** recommendations by the Lead Director.

Table 1

Lead Director	Chief Operating Officer	Director of Corporate Governance	Director of Digital	Director of Finance and Procurement	Director of Nursing	Director of Public Health	Director of Strategy, Planning & Partnerships	Director of Workforce	Director of allied health professionals	Total
Total recommendations requiring an update	11	8	16	20	14	9	3	4	3	88

The position reported in Table 2 reflects the position following updates received from Lead Directors against their overdue recommendations. The Committee is asked to approve **31** revised deadlines and **56** completed recommendations.

Table 2

Lead Director	Chief Operating Officer	Director of Corporate Governance	Director of Digital	Director of Finance and Procurement	Director of Nursing	Director of Public Health	Director of Workforce	Director of allied health professionals	TOTAL
Revised Deadline	4	4	8	0	7	4	1	3	31
Completed	7	4	8	20	7	4	3	0	56
Residual Overdue against Deadline	0	0	0	0	0	1	0	0	1

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

- **Table 3:** Details the **31** revised deadlines. (See Appendix A for revised implementation dates)
- **Table 4:** Lists the **1** residual overdue recommendation. (See Appendix B for details)
- **Table 5:** Highlights the **56** completed recommendations. (See Appendix C for details)

Table 3



REVISED DEADLINES		
Audit Year and Title	Assurance Rating	Number by Priority Rating
2020 IM&T Control & Risk Assessment 2020/21	Not Rated	3
2022 Dementia Services	Reasonable	1
2022 Discharge Planning	Limited	2 1
2022 IT Strategy	Reasonable	2
2022 Monitoring Action Plans	Reasonable	1
2022 Structured Assessment	Not Rated	2
2022 Tredegar Health & Wellbeing Centre	Limited	1
2023 Clinical Coding; Final Internal Audit Report	Reasonable	1
2023 IT Infrastructure	Reasonable	2
2023 Medical Equipment & Devices - Ultrasound	Reasonable	2 1
2023 Newport East Health and Wellbeing Centre	Reasonable	4
2023 Putting Things Right; Final Advisory Review	Reasonable	1
2023 Review of Workforce Planning Arrangements	Not Rated	1
2023 Risk Management	Reasonable	1
2023 Structured Assessment	Not Rated	2
2023 Waiting List Management	Reasonable	1
2024 Energy Management	Reasonable	1
2024 Reinforced Autoclaved Aerated Concrete – NHH	Reasonable	1
TOTAL		31

Table 4

Audit Year and Title	Assurance Rating	Number of Overdue Recommendations by Priority Rating (No revised deadline)



2023 Newport East Health and Wellbeing Centre	Reasonable	1
TOTAL		1

Table 5

COMPLETED RECOMMENDATIONS			
Audit Year and Title	Assurance Rating	Number by Priority Rating	
2020 IM&T Control & Risk Assessment 2020/21	Not Rated	1	
2021 IT System Controls WRIS	Reasonable	1	
2021 NIS Directive Cyber Security	Reasonable	1	
2022 Dementia Services	Reasonable	2	
2022 Discharge Planning	Limited	2	
2022 IT Strategy	Reasonable	1	
2022 Policies	Limited	2	1
2022 Robotic Process Automation	Reasonable	1	
2023 ABUHB Financial Controls – Regional Leadership Board	Limited	4	8
2023 Decarbonisation	Limited	1	2
2023 IT Infrastructure	Reasonable	2	
2023 Newport East Health and Wellbeing Centre	Reasonable	3	1
2023 Savings Programmes Internal Audit Programme	Reasonable	1	
2023 Audit of Accounts Addendum	Not Rated	4	
2023 LINC Programme	Reasonable	2	
2023 Primary Care Follow Up	Not Rated	1	
2023 Putting Things Right Final Advisory Review	Reasonable	2	1
2023 Review of Workforce Planning Arrangements	Not Rated	3	
2023 Estates Condition	Limited	1	



8 of the **15** (3rd – 7th extension) are being reported in this reporting period (**Appendix D**) and the remaining **7** have been presented to the committee at previous meetings. Further details can be found in table 6 below.

Table 6

Column A	Column B	Column C
Deadline position	Total number of Recommendations (including the 8 at Column C)	Recommendations which exceed the extension threshold within the reporting period (Appendix D)
Original Deadline	20	N/A
1 st Extension	24	N/A
2 nd Extension	22	N/A
3 rd Extension	8	(3)
4 th Extension	5	(3)
5 th Extension	1	(1)
6 th Extension	0	(0)
7 th Extension	1	(1)
Total	81*	8

*Including the **1** remaining outstanding recommendation (**Appendix B**) and **8** recommendations that have exceeded the threshold (**Appendix D**) and **NOT** including any recommendations from reports presented at this committee.

Argymhelliad / Recommendation

The Audit, Risk & Assurance Committee is asked to:

- **APPROVE** the revised timescales for the **31** Recommendations;
- **NOTE** the status of the **1** overdue audit recommendation;
- **NOTE** the completion of **56** audit recommendations; and,
- **NOTE** the ongoing efforts to ensure timely completion of recommendations.

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



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

Gwybodaeth Ychwanegol: Further Information:

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

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

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



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Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Priority	Recommendation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC Committee	Final Report Deadline Status	Revised Deadline Status	Number of revised Timescales Requested including new request	If closed and not complete please provide justification and ensure evidence is available	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close/complete the recommendation?	Reporting Date
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R6	R6 Consideration should be given to the placement of all informatics provision and support across the Health Board. As part of this the current partially decentralised model should be re-assessed in terms of its suitability for the modern use of technology.	Accepted. Following the exec review of the Target Operating Framework and overarching governance will appraise the hybrid environment of departmental asset ownership, responsibility, risk management. As the report sets out this is a largely historical and organic model which will be complex to resolve in itself. A risk based approach will be adopted and an options paper will be developed for consideration by the Board.	31/12/2022	-23.97	31/12/2025	11.97		Overdue	Overdue	4		"January 2025 Internal Audit have been tasked to undertake a specific audit of Shadow ICT as part of their 2025 audit plan. The organisational change process for Service Management structures is underway and due to complete April 2025." June 2024: Phase 1 of the structural changes are underway to support formalisation of Service Management structures and WPAS product team. Job description development is underway for senior roles across the directorate. January 2024: The target operating model has been reviewed by the new Director of Digital and a proposal on the revised structure will be presented to the Executive Committee in April 2024. This structure will bring forward some options on the current decentralised model in some departments.				31/12/2024
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R1	R1 The governance framework for IM&T / digital should be clarified and where control over aspects of IM&T has devolved to departments, there should be a process for these to feed into the relevant Committee to ensure oversight. Underneath the Committee the steering group remit and membership should be defined.	Agreed. The Health Board is establishing a new governance framework. Currently Informatics is reporting to the Audit Committee, the first report is scheduled for 8th April. A Health Board governance framework is in development for informatics including exec oversight, investment and delivery. The management of the global pandemic has disrupted the planning work by 12 months but this is now re-initiated. Recommendations are scheduled to be presented to Exec Team Q1, and Board in Q2;	30/06/2021	-41.97	31/03/2024	-9.02		Overdue	Overdue	7		"January 2025 Meeting held with chair of Clinical Council and reporting arrangements agreed. Terms of reference finalised for Digital, Data & Technology Sub-Committee and will be taken to the Executive Team for approval by the end of January will first meeting planned for March." October 2024: Meeting taking place with chair of the clinical council to review terms of reference and agree reporting arrangements, this will take place at the end of October. August 2024: Agreed that the clinical council will report into the wider Health Board's clinical advisory group so terms of reference now being reviewed to note this change. June 2024: Sign-off of the terms of reference has been delayed to the end of June to ensure consideration of clinical engagement and the role of the clinical council in the governance structure. March 2024: The Information Governance, Health Records and Cyber Security governance groups are now meeting and the first Information Governance Sub-Committee is being held on the 26/03/2024. The				31/12/2024
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R9	R9 A network of champions across the organisation should be established. The Digital Strategy should be re-issued alongside the roadmap. This should form the basis for engaging the network of champions to drive the Strategy forward.	Accepted-The Channel 3 report also identified a need for more emphasis on Clinical Leadership, Design and Business Partnering. This is subject to additional investment although recently the appointment of a full time CNIO/CSO has been a significant step forward. Outwith the Directorate recommendations will be presented to Execs on overarching exec level oversight which is intended to both strengthen accountability but also to ensure Informatics capacity is used to best effect. Benefits realisation training has commenced in Informatics and will form part of reporting. It is in principle agreed that the Health Board adopts a single methodology and framework that should be co-produced to manage all priority investments.	30/09/2021	-38.95	30/09/2025	8.95		Overdue	Overdue	5		"January 2025 Digital champions across all in-patient areas for WNCR Digital Clinical Council reformed and meeting 5th Dec '24, Reporting to Clinical Advisory Forum At the request of Planning, the development of a new Digital Transformation Strategy for ABUHB will commence once the ABUHB 10 year strategy has been agreed. An OCP has been agreed and will be consulted on in Q4 2024/25 that includes a refreshed strategy, planning and engagement function that will further develop stakeholder engagement at local, regional and national level. ""August 2024: Digital Champions in place through the M365 Team. Business partnering to be reviewed by DDaT Senior Leadership Team" January 2024: The Digital Champions network for Microsoft 365 has been relaunched and there are plans to further develop this through networking events and lunch and learns. Similar networks are being planned for Analytics and the refreshed Clinical Council. Nov 23: Progress has been				31/12/2024
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	Medium	R2	The role of the CCIO and CNIO should be fully defined.	2.1a The CCIO currently has an AMD role profile. There has been discussions for some time in terms of role design and accountability with the CCIO MD CEO and CDO. A model role profile based on the Faculty of Clinical Informatics example has been agreed and is now being localised. The CNIO has a full role profile and agreed Job description	01/06/2023	-18.98	30/04/2025	3.93		Overdue	Overdue	3		"January 2025 A clinical lead workshop is being held in the first week of February and this will be used to frame the future of clinical engagement and leadership of digital. "October 2024: CNIO JD reviewed and shared with Digital Director and Assistant Director of Nursing for consideration. March '24 - no confirmation of resourcing to support clinical engagement. Position not changed. CNIO position to be reviewed with Digital / Nursing directors with the retirement of current CNIO in July '25 Jan 24: Future arrangements and resourcing to support the clinical engagement across the Health Board will be presented to the Executive Committee in early March. This will create a formal structure of CNIO and CCIO's and a relaunch of the Clinical Council. Nov 23: CNIO role established. Work continuing on formalising the CCIO role. Aug-23: CNIO aspects of this have been met				31/12/2024
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	Medium	R3	Leads within divisions should be established to work with the CCIO / CNIO	The principle of Divisional Leads is accepted by the health board. The proposition now needs to be explored and defined in a proposal by the CCIO and CNIO to the Digital Delivery Oversight Board.	01/06/2023	-18.98	30/04/2025	3.93		Overdue	Overdue	3		"January 2025 A clinical lead workshop is being held in the first week of February and this will be used to frame the future of clinical engagement and leadership of digital. "October 2024: Clinical engagement model still not approved. Council being reformed Dec '24. Workshop being undertaken with clinical leads in early November to discuss arrangements going forward. March '24 - Dependency on agreement of clinical engagement model. This can not be undertaken until that is agreed. HAR group review has identified a number of stakeholders who would like to join the council Nov 23: Council not met for several meetings due to capacity issues and will need to be considered due to winter pressures so ToR will be looked at when we meet again Aug-23: Clinical Informatics Council in place and meeting scheduled every 6 weeks, however service pressures have resulted in over half the meetings this year cancelled. More formal job planning needed to release resources to attend	Lack of job profiling to support time to release clinical staff to attend			31/12/2024

Internal	2022.18	Monitoring Action Plans	Reasonable	Director of Nursing	Low	R2	Management should review the number of actions raised within the HIW reports and the number of actions noted within the reports sent to committees for accuracy. Management should ensure no actions have been missed from the HIW report	The Health Board agrees with this recommendation. An update to the SOP will be developed to ensure a Quality Assurance check is undertaken, confirming that all actions have been captured and referenced	01/05/2023	-20.00	31/03/2025	2.95	Overdue	Overdue	4	January 2024: AMAT training provided to Divisional colleagues. Action Plans with outstanding actions currently being added to the inspection module on AMAT. In process of moving all inspections onto AMAT. The system will automatically generate reports, to include number of actions identified." June 202412/06/2024 Not yet complete, further training on AMAT required					31/12/2024
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	High	R3.3	A consistent discharge approach is adopted for all day care appointments and for inpatient transfers between Health Board sites	In respect of day care episodes of care, there are many diagnostic / treatment areas and specialities who have different methods of notifying both the GP and patient of the care episode. We acknowledge that this is not a standard approach with some departments combining the clinical details as the discharge summary. As part of the Task and Finish group, the Assistant Medical Director for planning will ensure that discharge notifications form part of the standardised approach. For inter-site transfers an SBAR is completed for every patient that outlines the patient's condition, diagnosis and any actions needed to be taken by the receiving site.	01/04/2024	-8.98	31/03/2025	2.95	Overdue	Overdue	2	January 2025: New SBAR/step down process rolled out w/c 6th January, review of new process at regular interval to flag any areas of concern, update at Integrated Discharge Board on 28th January, survey to staff at 3/6 months to evaluate the new process. Assistant Medical Director to focus on ensuring that discharge notifications form part of standardised approach through pilot of 'perfect week' in January/February with completion of a standardised approach end of March 2025 June: SBAR documentation is embedded and used as standard in all inter site transfers. SBAR has review periods to make sure it is current and user friendly to ensure the correct information is on the document . The SBAR was reviewed May 2024 and new version will be rolled out August 2024					31/12/2024
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Medium	R7	We recommend that the Health Board continue to analyse the reasons behind re-admissions within a suitable period of time. Where themes and trends are identified that these are investigated further	The analysis of readmission rates is acknowledged as being problematic, as without clinical input at the time of readmission, our current systems are unable to differentiate between a readmission for a reason connected to a prior episode of care, or one that relates to a completely different clinical scenario. CHKS, which is the national benchmarking solution choice for Wales looks at the number of patients who have been readmitted regardless of specialty, consultant, diagnosis etc. This makes any analysis difficult to interpret or perhaps meaningless. The planning department is currently working with clinical teams to develop a number of meaningful measures to determine and understand readmission trends, and to identify where improvement is required. A number of data viewers have been developed and can provide 'bespoke' data by request. Moving forward, these measures will be included within the outcome measures and QPS insights. The Health Board has dedicated services to address frequent or 'high impact'	01/10/2023	-14.98	31/03/2025	2.95	Overdue	Overdue	2	January 2025: Readmission rates to be monitored as part of the optimal ward model, across three wards at RGH, Medicine, Community and Surgical, identifying reason for readmission aligned to the 50-Day Integrated Care Winter Challenge. Enhanced resource in Corporate Performance team to support analysis of discharge data and information. Optimal ward model to commence 6th January with an evaluation point at end of March 2025 October 2024: The HB currently has the ability to monitor re-admsion rates, categorised as failed discharges, this can be broken down by site, speciality, ward, time and day of the week. June 2024: An initial meeting has been held and a scoping document is being prepared to develop a business case for a new data capture system to enable greater depth of analysis on discharge data and infromation March: There is work ongoing to streamline data analysis, to ensure data is more meaningful and will enable the monitoring of trends. The Executive Director of Nursing and Digital have a meeting to review this in April. Progress will be monitored on an ongoing basis via the Integrated Discharge Board. January 2024: A review of the data and audit requirements for discharge is planned, the systems					31/12/2024
Internal	2022.20	Tredegar Health & Wellbeing Centre 2023	Limited	Chief Operating Officer	Medium	R4	Management should obtain signed lease agreements with relevant parties at the earliest opportunity	Agreed. The provision of signed lease is being actively addressed so that they are in place well before the planned occupation of the building.	01/06/2023	-18.98	31/03/2025	2.95	Overdue	Overdue	4	January 2025: "All 4 lessees are there or there about, the main sticking point is the service, once advised if it's the demies and shared space or just the demies, we will be able to advise cost which will allow HB to move forward. Dentist – Is happy to sign once he has the Service agreement cost. He has also asked about reduction in rent. I think we can achieve this by spreading the furniture repayment across a longer period. He has also agreed to take ownership of the dental chairs and will replace himself when required. Pharmacist – Happy to sign once the full service charge costs are finalised. Glan Yr Afon – Need to complete the room schedule assessment being conducted by SSP and ABUHB, which will be completed by the end of the month. Can then advise on the service charge. Tredegar – Once a full service charge costs can be advised I think the Practice will sign the lease. "October 2024: There have been meetings with all parties in the HC and have agreement in principle that they will all sign a lease. The holding point at the moment is the level of Service	None	N/A			31/12/2024
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Low	R4	Consideration should be given to formally monitor (e.g. set KPIs) and report on • patients hospitalised outside of their catchment areas; and • moved from one hospital site to another one over their treatment time.	Workstream 5b (measurement) will consider appropriate KPI's and will extend an invitation to the Patient Flow Team to be members of the workstream	01/08/2023	-16.98	31/07/2025	6.95	Overdue	Overdue	2	January 2025: There has been little progress on this objective but discussions are taking place within the Goal 1 discharge flow meetings. Patient flow team are invited to the ABUHB Dementia steering group but due to capacity and demands they have been unable to attend.. this will continue to be an action for improvement. March 2024: The Dementia Hospital Steering Group implements the All Wales Dementia Hospital Charter and as such are reviewing the KPI for measurement. The CWS Alert will help us to provide a framework to capture, admission, discharge, hospital moves and incidents. This Alert has been introduced in March 2024 and will be monitored and actions evolve as information is reviewed. The patient flow team have a regular invite to participate in the Dementia Hospital Steering Group. Nov 2023: Work stream 4 is the Hospital Dementia Friendly Charter, patient flow team have been invited to attend this meeting. There is also a audit parameter under the National Audit of Dementia. This will take a focused action as this aim is part if the wider hospitia admission and discharge work.					31/12/2024
Internal	2023	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	Medium	R5	Complaint case analysis detail level should be sufficiently granular, to provide learning to recipients and to prevent reoccurrence.	Review of all QPS resourses being undertaken via an OCP will include learning. A review of divisional QPS structures and asurance mechanisms will be require following OCP this will form part of a wider delivery plan for the Quality Strategy and a clear accountability framework between the ursing Directorate and the Operational Divisions for QPS.	31/12/2023	-12.00	28/02/2025	1.93	Overdue	Overdue	2	Learning Events and patient stories have been undertaken specifically around the complaints process. Patient participation panels have been undertaken with future panels planned.The Quality Patient Saftey Learning and Improvement Forum is now established, complaints/ compliments/ PSOW/ QPS learning is shared via this forum. Themes of complaints will be coded at point of receipt. Link back to CIVIA and PALS regarding data with future focus on areas of concern. Actions and learning will be captured on datix. June 24: A centralised Learning Repository is also being developed which will provide a live bank of actions undertaken, updates. This will be supported by the utilisation of the actions functionality in Datix Cymru, which supports monitoring, ownership and accountability. March 2024: The orgaisational OCP has now concluded and the QPS teams have moved centrally. Job Titles and Descriptions are being reviewed to include Learning and Quality Improvement. Learning captured onto action plans and held on datix. QPS and divisional leads to be trained by ABCI team to become Quality Improvement Coaches via spread and scale approach. High level themes identified and learning and QI to focus on the specific themes and learning shared widely accross the organisation. Goverance reporting					31/12/2024

Internal	2023.03	Clinical Coding; Final Internal Audit Report	Reasonable	Director of Digital	High	R4.2	We recommend that the Health Board devise a plan to address the longstanding underperformance in clearing the backlog of uncoded episodes. The performance of the plan should be reported regularly to the Board or an appropriate forum.	Backlog of episodes will be systematically coded when the new Clinical Coding Structure is implemented. The new structure provides the workforce with the capability to deliver on the monthly coded episodes target and address backlog.	30/06/2024	-6.03	31/05/2025	4.95	Overdue	Overdue	2		January 2025 There are 2 vacancies out for recruitment, when these are appointed to the new structure will be complete. 5 trainee coders have been appointed and have started in post during the past month."Recruitment to implement the new Clinical Coding structure is on going and estimated to complete by end of September. When the structure is completed, incremental improvements towards the monthly target will commence. Jan 2024: Backlog of episodes will be systematically coded when the new Clinical Coding Structure is implemented. The new structure provides the workforce with the capability to deliver on the monthly coded episodes target and address backlog.Requires recruitment to new structure as above					31/12/2024
Internal	2023.12	Risk Management	Reasonable	Director of Corporate Governance	Medium	R1.1	The Digital Directorate should ensure that there is no additional risk exposure through the current approach of recording divisional risks. Risks should be migrated to Datix as soon as functionality within the software becomes available	The Health Board is still waiting for an implementation date for the Once for Wales Risk Module (RLDatix). In the interim, the Head of Corporate Risk and Assurance is working with the Head of Health and Safety to improve the risk reporting form on the Datix legacy system, as the current format is onerous, overly complicated, and easy to override required sections. The Once for Wales Datix Risk Module is being trialled in Powys and has been well received; thus, the risk recording form from the RLDatix system will be replicated in the Datix legacy system to aid in the migration of locally held risk registers to Datix. The Digital Directorate will test the new form by adding all its risks to Datix. Training on the Datix system will be provided to ensure that all Datix Users within the Directorate understand how to use the system to manage risks and run reports to gain insight into the Directorate's risk exposure.	30/09/2024	-3.02	30/09/2024	-3.02	Overdue		1		January 2025: Health Bodies across Wales have collectively decided not to implement the Once for Wales Risk Module (RLDatix). Feedback from our trial area, the Digital Directorate, alongside input from other Health Bodies, concluded that the system was unfit for purpose. Consequently, the Health Board will continue using the Datix Legacy system until 2027 or until a suitable replacement is procured. The Digital Directorate has expressed concerns that transferring its risks to Datix Legacy would represent a step backward compared to their current system. They remain reluctant to use Datix Legacy as their primary database, highlighting that their existing system (SharePoint) is far more effective for their needs. It is important to note, that the Digital Directorate is one of the more advanced services in terms of risk management. They maintain a strong working relationship with the Corporate Risk and Assurance Team and have successfully aligned their risk management practices with the Risk Management Framework. This alignment ensures that risks are managed at the appropriate level and escalated in line with established thresholds.					31/12/2024
External	2022.03 EA	Structured Assessment 2022	Not Rated	Director of Corporate Governance	N/A	R2	R2 Information presented to Board and committees does not always provide the required assurance. Some papers are too long, detailed, and technical. Cover reports continue to follow an SBAR format, but there is variation in their use. The Health Board, therefore, should develop training and guidance for Health Board staff around the reporting expectations and quality of information presented to the Board and its committees.	The Health Board arrangements to ensure the quality and timeliness of information presented to Board and committees still require strengthening. Papers are generally clear and contain the information required for effective decision making. However, there are issues concerning the Health Board's Integrated Performance Dashboard, IMTP progress report and financial reports relating to data quality and timeliness, a lack of information on whether intended outcomes of improvement actions have been achieved and limited benchmarking of performance with other Health Board's. We also found the presentation of some information in supporting papers and appendices unclear. Board and Committee reports can be overly long and detailed, and there are opportunities to better summarise the information (see 2023 recommendations 2 & 3) this should help reports focus on key matters and reduce the overall volume of papers for Board and Committee meetings.	31/03/2023	-21.02	30/09/2025	8.95	Overdue	Overdue	2		January 2025: This work has been delayed due to unforeseen vacancies within the corporate governance directorate. Recruitment is underway. A process to procure board development support is also underway which will include a focus on effective report writing and presentation. March 2024: Revised report templates will be developed and rolled-out for the new financial year, with supporting guidance. The provision of report writing training will also be explored.					31/12/2024
External	2022.03	Structured Assessment 2022	Not Rated	Director of Nursing	N/A	R3	R3 There is limited use of patient and staff stories at Board. The Health Board should consider how it can increase and maximise the benefit of patient and staff stories in Board and committees to help centre and focus meetings on the things that matter most, and to help triangulate this intelligence with formal agenda items.	A Digital Story Protocol for staff and patient stories is currently under development and once approved an electronic digital repository of stories will be created. Digital Story Telling training has been commissioned. The CIVICA Citizen Feedback System now allows people to leave narrated stories. A selection of these will be played at the start of every Board meeting. The Executive Team will agree a programme of staff and patient stories that help triangulate intelligence with formal agenda items.	31/03/2023	-21.02	31/03/2025	2.95	Overdue	Overdue	3		January 2025A number of digital stories have been made and there are a number in progress. These are presented via various forums including Board and at learning events. A new consent form has been developed and a version is now included in the digital story to ensure governance and compliance with GDPR. Digital Toolkit will be concluded by the end of March 2025. This will be available on the Patient Experience and Involvement intranet page. March 2024: Digital Story repository now being considered on an all Wales basis. In the meantime, the Patient Experience Team will oversee all digital stories and manage in person attendance at Board. Where possible these will align to presented papers. June 23: A Patient Experience & Involvement Strategy has been developed which includes Digital Patient Narratives and Stories. A patient story has been presented at a Board Development Session and PQSOC this year. All Wales Experience Team reviewing. Review December 2024 Update July 2023: The Digital Story Protocol is drafted but is now being revised due to recent decisions to support 'in-person' patient experiences at Board. To date, a patient story has been played at each					31/12/2024
External	2023.04 EA	Structured Assessment 2023	Not Rated	Director of Corporate Governance	High	R2	The Health Board should develop training for Health Board staff around the reporting expectations and quality of information presented to the Board and its committees.	The Health Board will be working to review and update its corporate report templates, alongside developing clear guidance and support for the preparation of Board and Committee reports. Securing additional training will also be explored.	30/06/2024	-6.03	30/09/2025	8.95	Overdue		2		January 2025: This work has been delayed due to unforeseen vacancies within the corporate governance directorate. Recruitment is underway. A process to procure board development support is also underway which will include a focus on effective report writing and presentation.					31/12/2024
External	2023.04 EA	Structured Assessment 2023	Not Rated	Director of Corporate Governance	High	R3	The Health Board should establish a robust quality assurance mechanism to review the quality of reports for its Board and Committees.	The Health Board is currently reviewing its Board and Committee administration processes, including key performance measures. This will include a focus on the quality assurance process with clarity on expected standards. This will also be supported by work in respect of report writing development in recommendation 2.	30/04/2024	-8.03	30/09/2025	8.95	Overdue	Overdue	2		June 2024 - This action is included within the Improving Board Business Action plan which is with the Director of Corporate Governance. The focus of activity has however been upon ensuring consistency of processes and procedures within board business through the development and agreement of a documented end to end process.	January 2025: This work has been delayed due to unforeseen vacancies within the corporate governance directorate. Recruitment is underway. A process to procure board development support is also underway which will include a focus on effective report writing and presentation.				31/12/2024

External	2023.05 EA	Review of Workforce Planning Arrangements	Not Rated	Director of Workforce & OD	High	R1.1	While the Health Board has a three-year People Plan, the current approach to strategic workforce planning is not balanced and instead biased towards shorter term transactional workforce solutions. The Health Board's current service model is not sustainable given current demand, and this is affecting the performance and financial position. The Health Board should update its 5 and 10-year planning process, including clinical futures plans and workforce projections to ensure that they appropriately support the implementation of financially sustainable service models.	The Health Board is currently engaging and will be consulting on a renewed long-term strategy up to 2035 throughout 2024. This will involve developing the strategic outlook to inform and develop workforce planning.	31/12/2024	0.00	31/05/2025	4.95		Overdue		1		January 2025: Initial draft is being developed following engagement during 2024. There will be a series of workshops end of Feb/early March to review the document and actions within it. The plan is to publish March/ May pending Board approval."					31/12/2024
Internal	2023.16	Medical Equipment & Devices - Ultrasound	Reasonable	Director of Allied Health Professionals	High	R1.1	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.	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	01/11/2024	-1.97	28/02/2025	1.93		Overdue		1		January 2025: This is the first update An initial piece of work has been undertaken to identify how many US machines we have in the organisation and how this aligns with the medusa records. The outcomes from the initial information gathering exercise highlighted a possible 83 units that were not linked to Medusa across several organisational sites. The EBME service has undertaken an exercise to physically check, electrically test and tag the units. Information has now been added to Medusa for 50 units with plans in place for the remainder. It is a case of having access to the units during non-clinical times. This has been difficult in recent weeks due to the limited EBME resource and the clinical pressures. High confidence that this work will be completed and Medusa up to date by end February. The Ultrasound governance committee will ensure a system of regular sample audit is in place and adhered with, to provide physical verification of all units over the course of a year. "					31/12/2024
Internal	2023.16	Medical Equipment & Devices - Ultrasound	Reasonable	Director of Allied Health Professionals	High	R1.2	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 databas	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.	01/11/2024	-1.97	28/02/2025	1.93		Overdue		1		January 2025 First progress update There has been an unavoidable delay in progress due to existing fault between the fixed asset register and the Medusa database. This has now been rectified. A requisite software update has also been completed. EBME have simultaneously aligned Ultrasound equipment on medusa with the fixed asset register as part of the physical verification and tagging exercise. Again, this has been impacted by critical winter challenges A process for periodic audit needs to be produced to be overseen by the US governance group. The recommendation can be completed once this is in place (end February 25) "					31/12/2024
Internal	2023.16	Medical Equipment & Devices - Ultrasound	Reasonable	Director of Allied Health Professionals	Medium	R2	We recommend that services using ultrasound equipment ensure all items are covered by appropriate service or maintenance contracts and are tracked centrally.	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 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.	01/11/2024	-1.97	30/06/2025	5.93		Overdue		1		January 2025: "This is the first progress update. An additional contract module for Medusa is available, however it has not been purchased to date. This purchase is being reviewed given the potential financial benefit to the organisation in maintaining robust information on management of service and maintenance contracts. If a decision is made not to purchase (either through finance pressure or module deemed not fit for purpose) then a less effective but adequate process can be put in place to reconcile contract/servicing information against US equipment. The organisation will have an accurate record of equipment once the physical verification exercise has fully completed. There is a risk that existence of multiple small-scale contracts with the same company is more costly than if these were aggregated and their set up linked into procurement journeys; this is only practicable through centralised process and equipment registers. FOR ULTRASOUNDS DEVICE CONTRACTS CURRENTLY MANAGED BY EBME CONTRACTS ARE CURRENTLY STORED IN PAPER FORM. COSTING FOR THIS ADDITIONAL MODULE HAS BEEN REQUESTED 21-01-25, AWAIT					31/12/2024
Internal	2023.17	IT Infrastructure	Reasonable	Director of Digital	Medium	R3	Infrastructure assets should be detailed within a single register / CMDB.	ABUHB partially accepts this recommendation. ITIL Best practice suggests that we have a Configuration Management System that may comprise several CMDBs to suit our environment. That being said there is a plan to ensure that all infrastructure assets are detailed within a single CMDB complete with hierarchies and dependencies, achieved through integration with live tools which will be hosted within our Halo ITSM tool.	30/11/2024	-1.02	30/06/2025	5.93		Overdue		1		January 2025 CMDB is now much more mature, with over 54000 assets and may interdependencies recorded allowing a service view to be taken of large elements of infrastructure. Further review to be undertaken in the summer.					31/12/2024
Internal	2023.17	IT Infrastructure	Reasonable	Director of Digital	Medium	R.2	A set of formal procedure documentation and guides for managing the infrastructure should be defined.	ABUHB accepts this recommendation. There is already a large amount of documentation available for infrastructure management – mostly done to coincide with our Service Desk Institute Audit of policies and processes. Gap analysis will be undertaken to ensure that comprehensive documentation is developed and maintained for all infrastructure services	31/07/2024	-5.02	30/06/2025	5.93		Overdue	Overdue	2		October 2024: The resources library continues to expand and is reviewed and updated regularly. Gap analysis is still to be undertaken July 2024 - The Resources area of the DDaT Sharepoint site contains approved and published policies and procedures that span the directorate. All of the document requirements for Service Desk Insitute Audit are here plus many others. A review with Head of ICT and team managers will be undertaken to identify and fill any gaps. January 2025 All technical teams are actively engaged in reviewing existing documentation and developing new documents where gaps have been identified. Resource library continues to expand, as does the Halo ITSM Knowledge Base, allowing teams to access timely and relevant information when dealing with incidents. Further review in the summer.					31/12/2024

Internal	2023.34	Waiting List Management Final Internal Audit Report.	Reasonable	Chief Operating Officer	High	1.1a	Management should review the process of managing waiting lists. A targeted approach to continual validation of patients ensuring they are on the correct pathways and are not duplicates should be undertaken.	The Planned Care Academy purpose is to ensure that education and training of staff becomes embedded into ways of working, to develop and support staff as well as improving the effectiveness and compliance with national requirements relating to management of patients on their pathways. The development of tools, bespoke training packages, policies and standard operating procedures has now been completed. Initial training will provide basic RTT knowledge targeted at new starters and staff whose dealings with patient pathways are minimal. This cohort must still understand the concept of the 26 week pathway and the consequences of failing to record information correctly and in real time. Advanced RTT training is aimed at staff who require a full understanding of the 26 Week Rules. A comprehensive range of WPAS modules have been developed mirroring the patient pathway and designed to be role based i.e. tailored training. The training will include DNA's, how to rebook, the rules around Non-Admitted, Admitted and Incompletes, how to	30/09/2024	-3.02	31/03/2025	2.95	Overdue	Overdue	1	Jan 2025: the OCP process within DDaT has not yet commenced therefore no progression has been possible in respect of the WPAS team undergoing train the trainer and fulfilment of the delivery arm. The training materials are complete, scenarios and competency tests created. The app is with the MS365 team to provide some further enhancements. Future progress of the workstream will be transferred to Information Services when the OCP is concluded as the current workstream lead is retiring. October 2024: OCP process beginning in DDaT, part of which is the creation of the WPAS team who are required to deliver the training. This process has now commenced. New revised training materials, user guides are complete together with scenario based training to test competency and understanding. An app is in the final stage of development to allow users to book onto training sessions and this will also include refresher training for existing staff. A soft launch is planned for mid November.				31/12/2024
Internal	2024.01	Energy Management	Reasonable	Chief Operating Officer	Medium	1.1	new strategic risk we will be requesting approval for in January.	AGREED – the draft Energy Work Plan shall be considered and developed in a “workshop” style session to be arranged for November 24. The developed plan will be passed through the Estates Decarbonisation Group for comment and any actions resulting from the workshop will be monitored via the same peer group. The plan will cover the remainder of 2024/25 as well as financial year 2025/26.	31/12/2024	0.00	12/02/2025	1.41	Overdue		1	Energy Team session undertaken in Nov24 to review and develop the draft Work Plan. The Work Plan and a progress update shall be presented at the next available scheduled Estates Decarbonisation Group (12th feb 2025). The Work Plan shall become standing agenda item to track progress and escalate issues (if required)			Development session completed 28NOV24. Final draft of Work Plan being finalised for presentation and progress update to next Estates Decarb Group 12.02.25	31/12/2024
Internal	2024.02	Reinforced Autoclaved Aerated Concrete – Nevill Hall Hospital	Reasonable	Chief Operating Officer	Medium	1.1	A concise RAAC management strategy should be developed to provide assurance that the Health Board safeguards its infrastructure and the safety of its occupants.	AGREED - The concept of a RAAC Management Plan was already being scoped with the Health Board's professional external advisors, prior to the fieldwork for this Internal Audit. The scope of this plan is being finalised with our advisors who will lead the production of this for the Health Board. This recommendation from the Internal Audit will inform the production implementation the Plan	31/12/2024	0.00	28/02/2025	1.93	Overdue		1	The Management Plan has been received from advisors and is being finalised with input from the RAAC Working Group. DDEF is linking with the DDEF for confirmation of onward cascade and discussion within governance forum.			needs to work through appropriate forum which will need to be scheduled according to such forum timetables	31/12/2024
Internal	2023.37	Newport East Health and Wellbeing Centre	Reasonable	Director of Public Health	Medium	5.1	The Project Board should re-examine the remaining risks and sufficiency of remaining contingency sums (demonstrating ongoing scrutiny and management of the project risks) through to completion.	The Construction Risk Register is revised regularly on a monthly basis and is led by the Projects Cost Advisor. Risks are robustly scrutinised with appropriate funding allocated against each risk. Due to the robustness of this process, the overspend on the project has been significantly reduced to £120k. Whilst recognising the project is still over committed, the risk has reduced substantially to the financial position which was being recorded at the start of the project, due to unforeseen risks to the project.	30/11/2024	-1.02	30/04/2025	3.93	Overdue		1	January 2025: Risk register continues to be review, with Project Risks actively being managed against the Contingency Pot. This will continue to be reviewed until the completion of the Project.				31/12/2024
Internal	2023.37	Newport East Health and Wellbeing Centre	Reasonable	Director of Public Health	Medium	5.2	The Capital and Estates Board should be advised on the potential impact (and further consequences if additional monies are required) on the discretionary programme, any reduction in other targeted investment priorities and associated risks in the event of additional Welsh government funding not being provided.	The financial position is discussed through the capital and estates group and is also reported and discussed at the Capital Review Meeting with Welsh Government. Financial position is also included as part of the financial reporting	30/11/2024	-1.02	30/04/2025	3.93	Overdue		1	January 2025: Capital and Estates Board are updated as part of the All Wales Capital Update. Project is currently being managed within the current financial budget of the Project. Should there be any additional funding requirement, this will now be managed through Discretionary.				31/12/2024
Internal	2023.37	Newport East Health and Wellbeing Centre	Reasonable	Director of Public Health	Medium	6.1	All project control forms should be consistently completed and appropriately authorised incl. cross references, date of signature etc., and identifiable at the Change Control Register.	Accepted The consistency of the project control forms has been addressed in line with the recommendation.	31/10/2024	-2.00	30/04/2025	3.93	Overdue		1	January 2025: Change control implemented in line with recommendation				31/12/2024

Internal	2023.37	Newport East Health and Wellbeing Centre	Reasonable	Director of Public Health	Medium	7.1	All Project Control Forms should be adequately completed to demonstrate authorisation and approvals in accordance with the Standing Orders (Scheme of Delegation) and/or project delegation limits prior to the issue.	Accepted The Project Control forms are completed in line with the Health Board Scheme of Delegation, but also in line with requirements under the NEC contract. Whilst acknowledging that the email provided with the signed document lacked detail, as advised there were number of meetings and discussions which took place to inform the decision to sign the PCF.	31/10/2024	-2.00	30/04/2025	3.93	Overdue	1		January 2025: Change control implemented in line with recommendation, but also ensuring adherence with the NEC Contract.				31/12/2024
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	High	R3.1	All patient discharges from the care of the Health Board are effectively controlled and evidenced by issuing a timely, completed discharge notification.	The Medical Director is aware that the timeliness of some discharge notifications needs to be improved. A letter was sent to all medical staff outlining their responsibilities in respect of timely discharge notifications in 2021. This is now being followed up by the Assistant Medical Director for Planning who will be leading a task & finish group to develop standardisation of approach. This work will aim to ensure that patients are able to leave hospital with their discharge summary / notification and ensure it will be sent electronically to the GP on the same day	01/04/2024	-8.98	31/03/2025	2.95	Overdue	Overdue	2	January 2025: CWS technical change to be completed by end of quarter 4, 'perfect week' to be delivered in January/February, linking with Divisions and operational teams, standardised approach to be complete end oOctober 2024: Assistant Medical Director to pilot 'perfect week', ongoing engagement with medical staff re completion of discharge notifications, identify areas to focus on for improvement by site/ward, link with ops team to re measurement/patient flow, streamlining of mandatory field to reduce time completing, CWS technical changes due early next year				31/12/2024

Appendix B Residual Overdue Recommendations

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Priority	Recommen- dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC	Final Report Deadline Status	Revised Deadline Status	Number of revised Timescales Requested	If closed and not complete please provide justification and ensure evidence is available	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close/complete the recommendation?	Reporting Date
Internal	2023.37	Newport East Health and Wellbeing Centre	Reasonable	Director of Public Health	Low	8.1	Project Control Forms should be completed with detailed descriptions that demonstrate Value for Money (VfM) and support informed decision making.	Agreed. More detail will be included in the detail to support more informed decision making.	31/10/2024	-2.00				Overdue								31/12/2024

Appendix C Completed Recommendations

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Priority	Recomm en- dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC Committee	Final Report Deadline Status	Revised Deadlin e Status	Number of revised Timescales Requested including new	If closed and not complete please provide justification and ensure evidence	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close/complete the recommendation?	Reporting Date
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R5	R5 R1 The governance framework for IM&T / digital should be clarified and where control over aspects of IM&T has devolved to departments, there should be a process for these to feed into the relevant Committee to ensure oversight. Underneath the Committee the steering group remit and membership should be defined.	Accepted. The CDO will present the recommended Target Operating Model to the HB which will include governance over Informatics as a Division and also departmental systems. Part of the framework will include decisions to procure and assurance processes not only for informatics division but informatics services owned outside. Part of adoption will help appraise strategic options in how the HB wishes to take this forward. Part of the SIRO objectives will set out the responsibilities for devolved asset owners and a performance management framework to identify risk and provide oversight. There is likely to be a resource impact in achieving this which will be subject to a business case.	31/03/2021	-44.95	30/11/2024	-1.02	12/11/2024	Comple- ted	Comple- ted	5		"January 2025 All Divisional monthly engagement meetings are in place. "October 2024: All Divisional meetings are in place bar Medicine . Meeting agreed, Awaiting confirmation of date of 1st meeting! August 2024: agreed format for Divisional Meetings with Mental Health, Families & Therapies and Medicine. Anticipate meetings will be in place by end of Q2 Mar 24 - Divisional engagement meeting dates for meetings are being established for Families & Therapies and Unscheduled care division and will be in place in April 24 subject to Divisional staff availability. A communications an engagement plan that covers all the activities of the Health Board will be developed in Q1 2024/25. An annual operational plan has been developed to provide a detail account of the delivery plan for 2024/25 to sit alongside the IMTP Digital Enabler section. Divisional meetings are in place for Clinical & Support Services, Scheduled care, Primary & Community care & Urgent Care. New Digital Service Requests are in place to ensure all new requests are reviewed by the Senior Leadership team on a fortnightly basis. The digital enabler component of the IMTP has been completed A Microsoft Team Planner board is in place to track progress and outcome of requests to			Divisional engagement meetings now in place with all divisions and is being used to discuss digital developments and prioritisation of work.	31/12/2024
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R2	R2 The Health Board should seek clarity over why the requests made to DHCW and the SMB for an integrated electronic process cannot be delivered. The Health Board should carry out an analysis to fully identify its needs for a Radiology system and seek to include these within WRIS or any future system.	We have tried to seek clarity and not had a full response.Arequest for CWS to include WCP for radiology reporting in the platformhas been formally raised. We have raised the need for end to end requesting as a health board to the collaborativeboard for RISP project.	31/03/2022	-32.98	31/12/2024	0.00	12/11/2024	Comple- ted	Comple- ted	2		"Jan 25- DHCW will not be developing RadIS now that is is end of life, with Soliton replacing it as a part of the RISP programme. We will be looking to set up integrated electronic requesting to make the request electronic to receive in Soliton as well as having a global PACS visible in CWS. Allowing clinicians to see the patients national radiology record. "Oct 24- We will be meeting with Philips/Soliton who will be the new PACS/RIS provider, clinical apps team in order to scope out the requirments of the RISP project and it's integration with CWS. Within this we will be looking to integrate the current CWS request form to make this electronic within our new RIS. If this isn't feasible then we will look to integrate the WCP requesting solution in CWS so there is an electronic requesting solution that integrates with our RIS at go live of our new PACS/RIS. The current go live is November 2025. January 2024: Please refer to completed assurance report. Aug 2023: The UAT has been passed and is with clincial apps and is being trialled in Primary Care on the 11/09/2023. There are discussion amongst informatics about integrating the WCP requesting within CWS and we have done early scoping exercises with a bussiness analyst reviewing this currently. May 23: The UAT has been passed and is with clincial apps and Mr Rice to look at.	Aug 2023: Required scoping, testing and development and planned for software development Needs to be agreed locally and product developed to suit ABUHB		Propose to close as an alternative solution has been proposed.	31/12/2024
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Low	R1	R1 For future iterations of the CAF there should be greater involvement of the system owners in the review of the responses.	ABUHB will ensure that in future iterations of the CAF there is greater involvement of System Owners	31/12/2022	-23.97	31/12/2024	0.00	09/07/2024	Comple- ted	Comple- ted	3		Reviews of the CAF are now undertaken as part of governance and assurance groups with divisional stakeholders."June 2024: Work to associate critical assets to critical systems is progressing well but some way from completion. All assets are within CMDb and all services within Service Catalogue, dependancy mapping is ongoing March 2024: Cyber continues to attend GAG (Governance and Assurance Groups) meetings when scheduled with divisions to highlight the need of Information Asset Owners (IAO) and Senior Information Asset Owners (SIAO). CSAG (Cyber Security Assurance Group) meeting has been postponed due to circumstances within the team, this will be rearranged when applicable. Attendees have been identified and agreed with the SIRO. Terms of Reference will be covered in the first scheduled meeting. January 2024: The Cyber Resilient Unit assessment is now scheduled for 22/01/2024. There was a pre assessment meeting arranged with the CRU before the new year to discuss scope and this included Information Asset Owners.There is strong engagement through our divisional assurance arrangements where regular meetings are held between the divisions and our cyber security team. This will be further strengthened with the Cyber Security Assurance Group which will be meeting for the first time this quarter. Nov 23: CRU assessment now scheduled for 22/01/2024. There will be a pre assessment meeting arranged by CRU in Nov/Dev to discuss scope and Digital will ensure this includes Information Asset Owners.			Divisional governance and assurance groups meet regular and discuss range of Information Governance and Cyber Security topics including progress against the CAF.	31/12/2024
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Low	R3	R3 The Health Board should consider the relevant Health and Care Standards when reviewing / updating a policy or other relevant documentation. An acknowledgement of this process should be included, together with the titles of the relevant Standards included.	The introduction of the Duty of Quality, under the Health and Social Care (Quality and Engagement) (Wales) Act 2020, will see the Health and Care Standards (April 2015) removed and replaced with Quality Standards 2023. As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), the introduction of the Quality Standards 2023 will be considered, and policy templates updated as they are reviewed/developed.	29/09/2023	-15.05	31/10/2024	-2.00		Comple- ted	Comple- ted	4		August 2024: Policy Management Framework to be presented to Board September 2024 (finalised and scheduled). This was deferred from July 2024 due to engagement with staff groups on the content. June 2024: work continues as previously described. Revised Policy Management Framework to be presented to the Board for approval in July 2024 March 2024: This will be included as part of the revised framework November 2023: This will be included as part of the revised framework	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues		Policy Management Framework approved by Board in September 2024	31/12/2024
Internal	2022.11	Policies	Limited	Director of Corporate Governance	Medium	R4	R4 The Health Board, alongside recommendation 3.1 should consider automating the submission of a policy from the responsible owner, to ensure that a consistent submission format is adhered to.	An integrated electronic policy management system will be explored, learning from other health bodies, with an implementation plan developed to support the most appropriate system.	29/09/2023	-15.05	31/10/2024	-2.00		Comple- ted	Comple- ted	4		August 2024: Partially complete. SharePoint system in place and automated flagging and reminder system established./ Review of templates and submission process included within the revised Policy Management Framework scheduled for submission to Board in September 2024. June 2024. Partially complete. SharePoint system in place and automated flagging and reminder system established./ Review of templates and submission process included within the revised Policy Management Framework scheduled for submission to Board in July 2024. March 2024: All policies are now managed via sharepoint, with an automated flagging and reminder system in place at 6 months prior to review, 3 months and when policy is overdue. A review of templates and submission process will be included in the revised policy framework being developed. November 2023: All policies are now managed via sharepoint, with an automated flagging and reminder system in place at 6 months prior to review, 3 months and when policy is overdue. A review of templates and submission process will be included in the revised policy framework being developed.	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues		Policy Management Framework approved by Board in September 2024	31/12/2024

Internal	2022.11	Policies	Limited	Director of Corporate Governance	Medium	R1	R1 The Health Board should review the types of policy documents retained and hosted, to determine if each of them should adhere to the Policy, for example, departmental standard operating procedures to be managed entirely within the respective division. Alongside this review, the document owner should be determined to ensure the responsibility remains with the most appropriate individual.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), clarity will be provided on which WCDs are to be held centrally and which are to be managed within services and teams. A review of the central base (881 documents) is underway, working with divisions, to review the status of each document and respective owners.	31/03/2023	-21.02	31/10/2024	-2.00		Completed/Closed	Completed/Closed	4		June 2024 Clarification of definitions of WCDs and Health Board vs local documents included within the revised policy framework, to be presented to Board in July 2024. March 2024: Policy Framework currently under review. This will provide clear definitions of policies, procedures, guidelines and what constitutes an organisational policy. Scheme of delegation to be developed to support organisational policies which will be monitored by corporate governance, and departmental policies which will be led by individual departments (but held within the overall database) November 2023: Policy Framework currently under review. This will provide clear definitions of policies, procedures, guidelines and what constitutes an organisational policy. Scheme of delegation to be developed to support organisational policies which will be monitored by corporate governance, and departmental policies which will be led by individual departments (but held within the overall database)	November 2023: Capacity/changes in roles within the team. Addressed via corporate governance re structure. Posts now in place and work continues		Policy Management Framework approved by Board in September 2024	31/12/2024
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	Medium	R4	Work should be undertaken to embed the Clinical Informatics Council and encourage participation therein	Agreed. The CCIO and CNIO will revisit the membership and Terms of Reference for the Clinical Informatics Council which will be included as part of ??	01/06/2023	-18.98	31/12/2024	0.00	12/11/2024	Completed/Closed	Completed/Closed	1		"January 2025 The clinical council is in place with formal reporting arrangements."October 2024: ToR updated, will now report to Clinical Advisory Forum. Meeting 5th December with refreshed membership March'24 - Dependency on agreement of clinical engagement model. This can not be undertaken until that is agreed Nov 23: Council not met for several meetings due to capacity issues and will need to be considered due to winter pressures so ToR will be looked at when we meet again			The refreshed clinical council met in December and will have dual reporting lines into the Digital, Data & Technology sub-committee and the Clinical Advisory Group.	31/12/2024
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Medium	R4.3	A method for identifying delays during the discharges of 'simple' cases should be introduced, monitored and reported	Discharge delays can affect both simple and complex discharges and therefore emphasis should be improving the process for all patients. Length of stay data is available to explore the feasibility and the benefits of such an approach. The Health Board continually seeks to identify the factors that delayed discharge and this work forms part of the workstream for goal 5 of the Welsh Government '6 Goals for Urgent and Emergency Care' programme. As part of this programme, the Delivery Unit has recently released the 'optimal patient flow framework', and the Health Board will be embedding these principles as 'business as usual'. The framework will also feature in the new All Wales Discharge Policy, to include the introduction of the SAFER principles, D2RA and 'red & green days'. These concepts have the potential to reduce LOS and improve discharge planning, so will be embedded within our policy.	01/04/2024	-8.98		-1496.95		Completed/Closed	Completed/Closed	2		October 2024: The pace of the roll out of the new HB digital system, CWS2, has increased significantly and will be completed November 2024. This will facilitate the capturing of both simple and complex discharges and will integrate with Qlik to provide live data capture. June 2024: the new All Wales Discharge Policy, to include the introduction of the SAFER principles, D2RA and 'red & green days', the Health Board has focused on implementing these principles and the new electronic management tool will enable collation of data to demonstrate the impact. These concepts have the potential to reduce LOS and improve discharge planning, so will be embedded however the electronic data system is currently being rolled out .			Roll out of CWS2 across all wards and sites to support the recording of data which includes D2RA pathway, Red to Green days, reason for delay and clinically optimised status aligned to the 'Optimal Hospital Flow Framework'. Development of ward dashboards to assist operational staff with identifying reasons for delayed discharge and support with timely discharge planning. Ongoing monitoring re compliance, training and education to improve patient flow and deliver timely pathways of care	31/12/2024
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Medium	R5	Determining whether to make the use of the discharge checklist mandatory (including which aspects to include) or not and if so, the document should be consistently completed. Performance should be monitored until fully embedded.	Discharge checklists are used by most wards; however, we acknowledge there is an inconsistent approach in their use. The Welsh Nursing Care Record is currently being rolled out across the Health Board and may provide the opportunity to make the checklist part of the digital record as part of a standardised approach. In the interim, the use of checklists will be reviewed as part of the Discharge Improvement Board workstreams. The use of checklists will be further defined in the new discharge policy.	01/04/2024	-8.98		-1496.95		Completed/Closed	Completed/Closed	1		October 2024: Discharge champions identified and teaching sessions underway. WNCR has been rolled out across the HB the discharge checklist features within this. June 2024: The Welsh Nursing care records are rolled out to all areas and the discharge documentation is audited to ensure compliance. Further work is ongoing through the Integrated Discharge board and focus groups to ensure that the checklist and discharge documentation is embedded meaningful and robust. This includes discharge champions in inpatient areas and a learning focus with the safer discharge group			Discharge Champions appointed - rolling programme of teaching sessions in place. WNCR rolled out across the HB - discharge checklist features within this. Further work being led nationally to refine with a lead in time of circa 1 year.	31/12/2024
Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Medium	R1	Formal deadlines should be set by the Health Board to ensure the timely delivery of actions to maintain compliance with the Standards. Performance against these deadlines should be monitored and reported on.	The Standards have been developed and published by Improvement Cymru. There are no National Deadlines set for the Standards. This is continuously evolving and will help all Health Boards/regions to influence, shape and improve dementia care over coming years. These are the first 20 Standards and we anticipate that new standards will be introduced by Improvement Cymru over the coming years. We have updated the Board and Quality Patient Safety and Outcomes Committee of work undertaken during the readiness year. The Regional Dementia Board consider all the standards which are part of the dementia action plan, and this is also fed back to the Regional Partnership Board. The newly appointed Dementia Programme Manager will oversee all workstreams and, alongside reporting progress, we will report by exception any issues relating to implementing the Standards. Should Improvement Cymru produce deadlines, we shall revisit this recommendation. Additionally, once KPIs have been	01/07/2024	-6.00		-1496.95		Completed/Closed	Completed/Closed	0		January 2025: There is a 6 monthly reporting template which is used to update the Regional Dementia Board and the national Improvement Cymru/ NHS Executives on the progress of the current All Wales Dementia Pathways of Care. October 2024: There isn't a standard data set required for the All Wales Dementia Standards of care. Each workstream within each Health Board is expected to update on improvements in care around the standards, which are ongoing. This is a standing agenda item on the Strategic Dementia Group and reported through the annual dementia report.	This is not an action which can be considered complete as the improvements in care are ongoing. But is complete in that there is a structure in place to monitor and record progress. Each workstream supports the All Wales Dementia Standards of Care, currently working on the agreed 20 standards. Each of the workstreams have a priority of objectives and a working action plan which supports the work. These action plans are reported into and to the Welsh		January 2025: monthly reporting template is in place and used by the Regional Dementia Programme manager to update the Regional Dementia Strategic Group and the NHS Executives (previously Improvement Cymru).	31/12/2024

Internal	2022.27	Dementia Services	Reasonable	Director of Nursing	Medium	R3	It should be clearly defined and communicated in what circumstance alerts should be used. In addition, staff should be trained on how to add alerts to the system	We will review the training and electronic filing requirements for 'alerts' and ensure that clear messages are communicated to the relevant staff	01/07/2023	-18.00	01/10/2024	-2.98	16/04/2024	Completed/Closed	Completed/Closed	1		March 2024: Applying an Alert to WCCIS was not achievable. The system is not HB wide and time limited. As part of the National Audit of Dementia and the Dementia Hospital Steering group and alert has been introduced for the CWS (Clinical Work Station). An alert will be displayed on patient record using an input code of 136. A briefing document, flow chart and review process is in place to monitor the impact of this as a measurement of people with dementia on our inpatient wards and attending out patient departments. The GP read codes for dementia diagnosis have been reviewed by WG and a reminder document disseminated across MAS and NCN. Primary care divisions.			January 2025: A staff briefing to outline the process of adding the clinical code for dementia 136 for clinical workstation was shared with ward teams, departments, added to the ABUHB Pulse Carousel and ABUHB intranet pages. The code information is shared at staff inductions, dementia training and is used as part of the National Audit of dementia audit.	31/12/2024
Internal	2023	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	High	R6	Actions to address the circumstances that have led to individual complaints and those that have been identified to address complaint themes through boarder learning pathways should be captured in actions plans. The delivery of the plans should be monitored by appropriate oversight groups.	Review all QPS resources being undertaken via an OCP which will include learning.	31/12/2023	-12.00	31/12/2024	0.00	12/11/2024	Completed/Closed	Completed/Closed	2		January 2025: Internal resrtucture of PTR teams including centralisation of the Medicine/Urgent care and DoS/CSS teams has occurred and this has already resulted in improved practices with complainant engagement and data validation. Ongoing quality improvement mapping sessions with the entire PTR team to bring uniformity and consistency. October 2024: October 2024: In May 2024 ABCI improvement team joined the central QPS teams. Quality Coach programme launched in September 2024. QI strategy in development. Patient Quality + Safety Learning and Improvement forum has been established. ABUHB Listening and Learning Framework and Learning repository launched. Listening and Learning divisional assurance agendas developed. Safe Care Partnership co-design to set All Wales platform and national direction October 24. October 2024: October 2024: In May 2024 ABCI improvement team joined the central QPS teams. Quality Coach programme launched in September 2024. QI strategy in development. Patient Quality + Safety Learning and Improvement forum has been established. ABUHB Listening and Learning Framework and Learning repository launched. Listening and Learning divisional assurance agendas developed. Safe Care Partnership co-design to set All Wales platform and national direction October 24.			Risk reduced to medium.	31/12/2024
External	2023.05 EA	Review of Workforce Planning Arrangements	Not Rated	Director of Workforce & OD	High	R4	We found that the Health Board had workforce planning training and support, particularly in relation to the opening of Grange University Hospital, however this was paused during the pandemic, and it now needs to recommence. The Health Board should develop and implement a programme of workforce planning training and once in place create an evaluation framework to measure the success of its training programme. (	Plans are in place in provide formal training and education in line with the newly revised HEIW workforce planning competency frameworks. The Health Board will also be introducing workforce planning awareness into existing training management and leadership programmes	31/03/2024	-9.02	31/12/2024	0.00	09/07/2024	Completed/Closed	Completed/Closed	1		"Jan '25 Update The timescales of this audit have changed to align to the suite of tools that HEIW are developing including the roll out of a bespoke Mental Health Workforce planning. HEIW are developing 4 levels of training (online, locally delivered, HEIW delivered and CIPD delivered). Training for Level 3 not yet completed or being delivered as this is highly specialist workforce planning and for those facilitating workforce planning training. Level 1 - 31 staff currently enrolled and completing the 5 modules. 15 people are enrolled on level 2 course for February internal course and 5 Mental Health and Workforce leads enrolled on the Mental Health Workforce Planning training. Due to limitations on spaces one application for level 4 was declined by HEIW for next intake. Further level 2 training is being planned for May 25. Workforce planning has also been incorporated in DX and CDX leadership training programme. Workforce planning toolkits and frameworks are accessible on the ABUHB intranet. "June 2024: "Introductions to workforce planning have been presented to both DDX and CDx programmes in May 24. Business case templates have been updated to reflect workforce planning requirements (May 24). The timescales of this audit will need to change to align to the suite of tools that HEIW are developing. They are developing 4 levels of training (online, locally delivered, HEIW delivered and CIPD delivered).			Workforce planning training is progressing across all levels of the Health Board.	31/12/2024
External	2023.05 EA	Review of Workforce Planning Arrangements	Not Rated	Director of Workforce & OD	High	R5	The Health Board is intending to update its strategic priorities, linked to a review of its Clinical Futures approach. While it is re establishing a Clinical Futures Workforce Group there is insufficient programme infrastructure to support service workforce redesign. Once the Health Board has revised its sustainable Clinical Futures models, it needs to ensure there is a workforce programme to support the necessary redesign and service transformation.	We agree that formal governance and programme arrangements are required to support the delivery of the Health Board Strategic priorities. The Workforce group has now been formalised to take forward the development and delivery of the workforce plans	31/12/2024	0.00		-1496.95		Completed/Closed	Completed/Closed	0		"Jan '25 Update Workforce programme aligned to current Clinical Futures workstreams and workforce plans have been presented to the Clinical Futures Workforce and OD Group. The Workforce and OD Group are also reviewing enabling actions including its toolkit to support organisational change."			Established Workforce governance arrangements in place and established	31/12/2024
External	2023.05 EA	Review of Workforce Planning Arrangements	Not Rated	Director of Workforce & OD	High	R7	Whilst the Health Board benchmarks with other health bodies in Wales, there is potential to benchmark with 'best in class' organisations and clinical models from outside of Wales. The Health Board should look to use benchmarking to inform plans for workforce redesign and service transformation ensuring similar system conditions, demographics and population characteristics make their comparisons valid.	We accept the recommendation to extend benchmarking and work with HEIW in this respect. The Health Board has a compendium of new roles to support and share good practice.The Health Board also has a dedicated intranet ite signposting to HEIW sites which also have compendium of roles. It draws on national workforce benchmarking and research when formulating its service workforce plans. This is in addition to workforce standards set by legislation and through respective Professional Bodies.	31/12/2024	0.00		-1496.95		Completed/Closed	Completed/Closed	0			Benchmarking and drawing upon best in class models will continue to be an elementary component of business cases and workforce planning strategies. There are established workforce planning networks and other benchmarking networks to support this. HEIW continue to populate Workforce Observatory to support this at a Regional Level on an ongoing basis.			31/12/2024

External	2023.06 EA	Primary Care Follow Up	Not Rated	Director of Corporate Governance	N/A	R3.3	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.	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.	31/12/2024	0.00		-1496.95		Comple ted/Clos ed	Comple ted/Clos ed	0				January 2025 : Primary care metrics are now included in the integrated performance report. Currently these are activity focused rather than outcome focused due to limitations of GMS and other contracts. Outcomes and metrics around broader community metrics such as Hospital to Home, Pathways of Care. Reporting against primary cares specific commitments is addressed as part of the quarter IMPT report with progress against key commitments outlined	31/12/2024
Internal	2023.17	IT Infrastructure	Reasonable	Director of Digital	Medium	R.1	The provision of the VPN from WAST should be formally documented within a service agreement.	ABUHB accepts that this should have been put in place but provision of VPN for RPA connectivity from WAST was only ever intended to be an interim solution. This will be discontinued as soon as the official solution from DHCW is available.	31/03/2024	-9.02	31/10/2024	-2.00	09/07/2024	Comple ted/Clos ed	Comple ted/Clos ed	1		"January 2025 The Interim solution utilising a VPN supported by WAST has now been replaced with a permanent solution furnished by DHCW."June 2024 - Interim Solution - Risk will be mitigated upon closure of risk r1.2		The WAST solution has now been completely replaced.	31/12/2024
Internal	2023.17	IT Infrastructure	Reasonable	Director of Digital	Medium	R.1.2	Work should continue with DHCW as the providers of the national infrastructure to move this service to DHCW.	ABUHB accepts this recommendation, and a request has already been placed with DHCW to provide VPN service for RPA and other services requiring this functionality	31/03/2024	-9.02	31/10/2024	-2.00	09/07/2024	Comple ted/Clos ed	Comple ted/Clos ed	1		"January 2025 Permanent solution now in place oin DHCW National Infrastructure."June 2024 - Awaiting DHCW - Service request Submitted		The WAST solution has now been completely replaced.	31/12/2024
Internal	2023.25	Decarbonisation	Limited	Director of Finance and Procurement	Medium	1.1	Management should identify the required training packages for its staff and which training needs be mandatory. Mandatory training should be monitored for staff compliance.	Training to date has been voluntary and supported through limited available funding, however awareness raising and voluntary engagement and involvement in the decarb, biodiversity and sustainability is promoted through the Board sub groups and the Health Board's extensive intranet site, with over 60 projects underway. It is agreed that it would be useful to implement a more structured training approach. However, mandatory training will need to be tested against the ABUHB Policy Group. Additionally, an appropriate e-training product would need to be developed or procured.	31/10/2024	-2.00		-1496.95		Comple ted/Clos ed	Comple ted/Clos ed				Staff Training - 2024 & 2025 Quality improvement coaches supported through ABCi Continued Carbon Literacy training through HEIW Promoting the ESR staff training modules 000 NHS Wales – Climate Change and Sustainability · 000 Building a Net Zero NHS · 000 Environmental Sustainability in Quality Improvement · 000 Healthcare waste management and disposal 317 Staff have been trained in Poded QI Poded QI is an ideal introduction to, or	31/12/2024	
Internal	2023.25	Decarbonisation	Limited	Director of Finance and Procurement	Medium	2.1	The specific risk that the Health Board is unlikely to reach the Welsh Government targets of 16% emissions reduction by 2025 and 34% reduction by 2030 needs to be clearly raised.	Agreed - this is already under consideration and a risk analysis is in construction for the Board.	30/09/2024	-3.02	30/09/2024	-3.02	12/11/2024	Comple ted/Clos ed	Comple ted/Clos ed	1		October 2024: Risk analysis being finalised end of October		07/24 - Risk 8791 closed as duplicate. Risk 7092 reviewed and updated and governance reviewed. Monthly directorate risk meetings in place to manage ongoing monitoring of risk. Joint risk review between directorate and DDaT established via formal monthly meetings. Risk assessment and report completed for December	31/12/2024

Internal	2023.25	Decarbonisation	Limited	Director of Finance and Procurement	High	3.1b	Management should complete an analysis of their progress to date with the decarbonisation plan. The percentage reduction or increase in emissions compared to the original baseline the reasoning for any increases should be captured. Management should seek dialogue with Welsh Government to agree an updated emissions baseline figure which reflects the changes in the Health Board's site since the original baseline in 2018/19.	Agreed – the re-basing of ABUHB carbon impact will also need clarity on National Procurement and other Shared Services data – something that has been repeatedly requested. A report has recently been received, post audit (attached). This will pursued as part of establishing a revised figure.	31/10/2024	-2.00		-1496.95		Completed/Closed	Completed/Closed					"The new DCR report has matured over the last 12 months along with both Qualitative and Quantitative reporting formats to NWSSP/WG. A suite of reports will be available to the health board in the coming months which will allow the decarbonisation board to accurately report on our Carbon reduction programme. In addition to the National dashboard C&V health board are progressing a carbon / project capturing database which will allow staff to identify the carbon related to a specific project area. Risk Assessment finalised January 2025"	31/12/2024
Internal	2023.32	LINC Programme	Reasonable	Director of Digital	High	1.2	Management should ensure that all risks in relation to the delay of the LINC programme on Pathology services have been considered and are reflected within the Directorate Risk Register. Current risks should be appropriately detailed in order to inform effective mitigating actions.	A risk workshop will be scheduled to ensure all digital risks are appropriately defined and logged on the Directorate risk register. A full review of existing risks will be undertaken to ensure they are appropriately detailed with associated mitigating actions logged	31/10/2024	-2.00		-1496.95		Completed/Closed	Completed/Closed			January 2025 All risks are now logged on the directorate risk register		The directorate risk process is now aligned with the Health Boards new risk framework.	31/12/2024
Internal	2023.32	LINC Programme	Reasonable	Director of Digital	High	2.1	Management should ensure that directorate risks are appropriately overseen, regularly reviewed, and actioned.	There is a monthly meeting held to review the directorate risk register. Following the risk workshop (referenced in management response 1.2), the Terms of reference for this meeting will be reviewed and aligned with digital project governance to ensure all risks, digital or otherwise and reviewed and regularly updated	31/12/2024	0.00		-1496.95		Completed/Closed	Completed/Closed			January 2025 All risks are now logged on the directorate risk register		The directorate risk process is now aligned with the Health Boards new risk framework.	31/12/2024
Internal	2023.33	Savings Programmes Internal Audit Programme	Reasonable	Director of Finance and Procurement	Medium	2.1	We recommend that the Health Board review the savings target shortfall and determine if improvements can be made to maximise the level of savings achieved. In addition, consideration should be given to tracking savings programmes into the next financial year.	Savings delivery and opportunities to maximise delivery is the subject of monthly budget holder review and the V&SB process. The annual plan / IMTP process requires all potential opportunities to be considered and identified, including past schemes delivery levels and review of previous potential schemes not progressed. This is integral to the financial management and savings approach for ABUHB, including the in-year work of the V&SB. Several of the 'opportunities' requiring a QIA assessment as part of the 24/25 annual plan are related to revisiting previously discounted proposals. Where schemes were delivered on a part year basis in a prior year the underlying financial positions include the full year effect where recurrent as part of developing the new year financial plan. Action – include 'explicit' action as part of 25/26 annual plan to confirm previous schemes have been reconsidered, as part of financial planning process.	31/12/2024	0.00		-1496.95		Completed/Closed	Completed/Closed					V&SB and monthly reporting process in place identifies opportunities, risks and progress of savings plans. The IMTP process also includes a full review of past opps not progressed and their ongoing status along with QIA process.	31/12/2024
External	2023.07 EA	Audit of Accounts Report Addendum	Not Rated	Director of Finance and Procurement	N/A	1.1	Clarity sought from Welsh Government on the accounting treatment prior to 24-25 drafting.	Welsh Government were contacted prior to the submission of the 2023-24 Annual Accounts and confirmed that the pooled budget transactions should be shown gross in the accounts. This issue was raised at the Technical Accounting Group where further clarification regarding pooled budgets was requested to be include in the 2024/25 Manual for Accounts so that treatment across all Welsh NHS bodies is consistent	31/12/2024	0.00		-1496.95		Completed/Closed	Completed/Closed					WG have agreed the ABUHB approach to be used nationally for 2024/25	31/12/2024

External	2023.07 EA	Audit of Accounts Report Addendum	Not Rated	Director of Finance and Procurement	N/A	2.1	Ensure there is a system in place to facilitate frequent and periodic scanning of assets, all assets on the Fixed Asset Register have a serial number or equivalent unique identified and assets are listed on the Fixed Asset Register individually.	In line with the financial control procedure (approved in July 2024) periodic scanning will be carried out by Health Board staff to ensure that all main hospital and community sites are verified during the financial year. Current resources do not allow for all assets to be scanned within the last quarter of the financial year. The approved financial control procedure for capital assets requires assets that are unable to be verified or RFID tagged to be manually verified by departments in year. The work to update the asset register with unique identifiers and serial numbers for all assets has continued in 2024/25. The work to split grouped equipment assets into individual assets with unique identifiers has continued in 2024/25. IT assets are not currently within the scope of the RFID tagging project and are currently planned to remain as grouped assets within the asset register.	31/12/2024	0.00		-1496.95		Completed/Closed	Completed/Closed					AB approach as described	31/12/2024	
External	2023.07 EA	Audit of Accounts Report Addendum	Not Rated	Director of Finance and Procurement	N/A	3.1	Signed versions of all contracts are retained and are available on request at the start of the audit. If any unusual instances occur during the year, information to be disclosed at the beginning of the audit alongside any relevant documentation.	The points above were discussed at the 2023-24 Annual Accounts review meeting. Action will be taken in year to ensure that all contracts are retained and available to Audit Wales at the start of the audit. Any unusual instances occurring in year will be highlighted to Audit Wales when the audit commences, with appropriate documentation provided	30/09/2024	-3.02		-1496.95		Completed/Closed	Completed/Closed					AB approach as described	31/12/2024	
External	2023.07 EA	Audit of Accounts Report Addendum	Not Rated	Director of Finance and Procurement	N/A	4.1	The Health Board should undertake regular, for example, every six months, user access reviews of ProLease. The Health Board system admins (for ProLease) should also monitor the audit log for what actions any MRI users have taken and to regularly review users with MRI staff access	The Prolease User Group have agreed that the Audit Trail report, Last log in report and User Access Report will be reviewed quarterly. This will include monitoring of access by MRI users.	31/10/2024	-2.00		-1496.95		Completed/Closed	Completed/Closed					AB approach as described	31/12/2024	
Internal	2024.01	Energy Management	Reasonable	Chief Operating Officer	Medium	6.1	Take-up data for the energy-related ESR training modules should be obtained and reviewed. If take up has been poor, communication should be increased to promote the training/awareness opportunities.	AGREED – this issue will be raised at the Decarbonisation Programme Board, requesting that the relevant sub-group of the Programme be tasked with updating AB Pulse Intranet content / links to sign-post users of the “Green Healthcare” pages to the additional ESR learning modules.	31/12/2024	0.00		-1496.95		Completed/Closed	Completed/Closed			This was raised and minuted at the Decarbonisation Prog. Board on 17th Oct 2024. Subsequent action taken by the Comms Sub-Group has been to identify and signpost the names of the ESR courses and publish the course titles on the “Green Healthcare” intranet pages:- “Building a Net Zero NHS”, “NHS Wales Climate Change & sustainability”, Environmental sustainability in quality Improvement” and “Healthcare Waste Management and Disposal” ESR Modules now available via Green Healthcare intranet pages				31/12/2024
Internal	2024.01	Energy Management	Reasonable	Chief Operating Officer	Medium	7.1	The UHB should liaise with NWSSP Accounts Payable to identify whether the current invoice payment process can be improved.	AGREED – ways to streamline the invoice payment process shall be identified and developed in the Energy Work Plan, with input from Finance and Accounts Payable as required. Meetings with energy suppliers shall continue, so that account queries can be rectified quickly and issues with payment delays	31/12/2024	0.00		-1496.95		Completed/Closed	Completed/Closed			Meetings with EDF Energy and Total Energies have continued on a 4/6 week basis to identify continued debt or account issues. This has proved useful to significantly drive debt down. Payment delays through Accounts Payable have significantly improved with only isolated invoices having to be resent. Liaison with NWSSP Procurement Energy Team is ongoing to identify best practice across Wales and to develop a process on how this will integrate with proposed Systems Link Energy Manager software development. Electronic EDI billing has been identified and discussions with EDF, TE and Systems Link have commenced to develop implementation. Electronic mark up of validated invoices has commenced thus avoiding printing/scanning of invoices to streamline the process and free up Officer time. Accounts Payable have now set energy invoices to immediate payment to streamline and cut down delays in payment. Further streamlining of the process TBC but dependent on future software improvements.				31/12/2024

Internal	2024.02	Reinforced Autoclaved Aerated Concrete – Nevill Hall Hospital	Reasonable	Chief Operating Officer	Medium	2.1	Retrospective approval for this specific award should be documented.	AGREED - This was a specific issue in relation to the cumulative cost of the regular scaffolding inspections. Retrospective approval will be actioned through the Director Estates and Facilities division and upwards in line with delegated limits	30/11/2024	-1.02		-1496.95		Completed/Closed	Completed/Closed			all approvals completed			Work is complete	31/12/2024
Internal	2024.02	Reinforced Autoclaved Aerated Concrete – Nevill Hall Hospital	Reasonable	Chief Operating Officer	Medium	3.1	Increased assurance should be provided within the Strategic Risk Report on the actions to be taken to manage/mitigate the risk and how this was linked to the achievability of the target score	AGREED – the risk score is set at 15 and will remain as a constant until alternative solutions to the estate are in place. This will be subject to service modelling and the submission of the full business case to Welsh Government. The agreed approach is reliant upon routine monitoring and the risk score will be expanded upon in the next Committee or Board update.	30/11/2024	-1.02		-1496.95		Completed/Closed	Completed/Closed			the most recent risk update included additional commentary			Process in place and following governance process	31/12/2024
Internal	2024.03	Facilities Stock	Reasonable	Chief Operating Officer	High	1.1	Reduced or maintained cost levels, continued stock counts with the focus on adherence to the Stock Financial Control Procedure (FCP) (as far as current system allows). Stock takes for Apetitooorders should not deviate from process noted in FCP. Alongside this, consider options 2 and 3 taking into account cost benefit analysis.	Agreed Action:The agreed action will follow an assessment of the three options available: Option 1 - Continue current processes which has resulted in reasonable assurance and proactively monitor (immediately) Option 2 – Improve the functionality of the existing system to deliver end to end stock management (discussions with the system provider are on-going) Option 3 –Source an alternative system	30/11/2024	-1.02		-1496.95		Completed/Closed	Completed/Closed			Centralisation of all the catering orders gives assurance that all stock is catalogue and any deviations to non- catalogue has to be approved and authorised by a senior facilities manager.			Process in place	31/12/2024
Internal	2024.03	Facilities Stock	Reasonable	Chief Operating Officer	Medium	2.1	Readily available training records, SOPs and improved training uptake.	Agreed Action: • Implement and maintain training records (immediately) • Ensure all SOPs are version controlled, assessed for training needs and formally acknowledged by staff (immediately)	30/11/2024	-1.02		-1496.95		Completed/Closed	Completed/Closed			SOPs in place and all version controlled, which has to be signed and understood by staff.			Process in place	31/12/2024
Internal	2023.28	ABUHB Financial Controls - Regional Partnership Board	Limited	Director of Finance and Procurement	Medium	1.1	1.1We recommend that the Health Board engages with the RPB to develop a documented process covering the payment deliverables provided on behalf of the RPB. Therefore, providing the RPB with details of key process points for ensuring each organisation fully delivers their outputs required. Any process could be extended to cover other outputs provided to the RPB.	The Health Board accepts that a refreshed agreement needs to be developed between the RPB and all partners in relation to providing clarity of roles and functions. This cannot take the form of a Service Level Agreement as the RPB is not a statutory organisation. However, following a governance review undertaken by the RPB a revised Memorandum of Understanding (MoU) is being developed for inclusion within the RPB Governance Framework document. The MoU has been drafted to include a set of financial procedures for the administration of partnership funding as well as clarifying the roles and responsibilities of organisation within the Partnership and of the Health Board in acting on behalf of the RPB and is awaiting ABUHB Executive sign-off, prior to RPB review.	31/10/2024	-2.00		#VALUE!		Completed/Closed	Completed/Closed					MOU presented to the Regional Leadership Group on 12th Feb 2025.	31/12/2024	

Internal	2023.28	ABUHB Financial Controls - Regional Partnership Board	Limited	Director of Finance and Procurement	Medium	1.2	1.2 We recommend that the Health Board develop a roles and responsibilities document (internal and external), detailing the process for receipting funds and the information required (including meeting minutes). This approach could be replicated to cover all outputs provided by the Health Board to the RPB and consideration should be given to including the deliverables provided by the Regional Partnership Team hosted by Torfaen County Borough Council, as they also impact activities.	As above, further clarity of the roles and responsibilities have been included within the draft MoU and the RPB Governance Framework, which is currently being reviewed by ABUHB Corporate Governance. However, this is not solely an action for the Health Board but all partners as part of the RPB Governance Framework. To ensure there is a clear differentiation of roles and responsibilities internally to ABUHB and appropriate segregation of duties, the process of raising requisitions, which currently is actioned by the PMO Finance Team, will be transferred to the PMO Team going forward.	31/07/2024	-5.02	30/11/2024	-1.02		Completed/Closed	Completed/Closed					Financial roles and responsibilities have been revised and established to provide better segregation of duties. Deputy D. of Planning - Leadership Group on 12 February to review MOU and remit of regional partnership team (TCBC)	31/12/2024
Internal	2023.28	ABUHB Financial Controls - Regional Partnership Board	Limited	Director of Finance and Procurement	High	2.1.2	We recommend that the Health Board ensures that clarity is provided by defining the purchase requisition and purchase order process for RPB funding payments, made by the Health Board on behalf of the RPB, indicating the level of detail required to be noted on purchase requisitions and purchase orders. This should include specific reference on the documents that payments may, or may not, be made in advance to third sector organisations, and may, or may not, include accruals claimed by the funding recipient where permitted by any funding award letter.	2.1.2 Payments to Third Sector Organisations The MoU referenced above has been set out to address this matter where by Third Sector Organisations can only claim funding monthly in arrears going forward. This information has also been reflected within the grant terms and conditions for 2024/25 and therefore not required for inclusion in the requisition detail.	31/07/2024	-5.02	30/11/2024	-1.02		Completed/Closed	Completed/Closed			August 2024: Draft Memorandum of Understanding is currently awaiting review by Corporate Governance and approval by ABUHB		Processes within the PMO now updated and in place	31/12/2024
Internal	2023.28	ABUHB Financial Controls - Regional Partnership Board	Limited	Director of Finance and Procurement	High	2.1.3	We recommend that the Health Board ensures that clarity is provided by defining the purchase requisition and purchase order process for RPB funding payments, made by the Health Board on behalf of the RPB, indicating the level of detail required to be noted on purchase requisitions and purchase orders. This should include specific reference on the documents that payments may, or may not, be made in advance to third sector organisations, and may, or may not, include accruals claimed by the funding recipient where permitted by any funding award letter.	2.1.3 However, communication to the organisations impacted by this change will need to be managed in line with the issuing of the grant award letter There are exceptional instances whereby a payment will need to be paid in advanced, for example, the funding for small grant schemes. This will be managed as noted in section 2.2.	30/08/2024	-4.03	30/11/2024	-1.02		Completed/Closed	Completed/Closed			August 2024: Draft Memorandum of Understanding is currently awaiting review by Corporate Governance and approval by ABUHB. However, in the interim, an SBAR was approved by the Execs w/c 5/08/24 following the guidance included in 10.6.2 of the Health Board's SFIs.		Revised arrangements include all payments in arrears unless specific extenuating circumstances are identified and uniquely approved by the RPB and ABUHB DoF (in line with ABUHB SFI's)	31/12/2024
Internal	2023.28	ABUHB Financial Controls - Regional Partnership Board	Limited	Director of Finance and Procurement	High	2.1.4	We recommend that the Health Board ensures that clarity is provided by defining the purchase requisition and purchase order process for RPB funding payments, made by the Health Board on behalf of the RPB, indicating the level of detail required to be noted on purchase requisitions and purchase orders. This should include specific reference on the documents that payments may, or may not, be made in advance to third sector organisations, and may, or may not, include accruals claimed by the funding recipient where permitted by any funding award letter.	2.1.4 Accruals The terminology 'accrual' was set out in the previous award letter. This has now been amended to 'costs incurred' by the organisation. This is to ensure that all committed costs are accounted for and claimed appropriately within the specified financial year. No further information is deemed necessary as there is a financial database and a portfolio register maintained with identifiable information of each scheme.	30/04/2024	-8.03		#VALUE!		Completed/Closed	Completed/Closed			August 2024: Draft Memorandum of Understanding is currently awaiting review and approval by ABUHB. However, in the interim, an SBAR was approved by the Execs w/c 5/08/24 following the guidance included in 10.6.2 of the Health Board's SFIs. The interim payments terms are reflected in the grants terms & conditions issued to the receiving organisation		"the word "accrual" has been replaced by "costs incurred" in the award letter – it was the word "accrual" that was causing the confusion so has now been resolved."	31/12/2024
Internal	2023.28	ABUHB Financial Controls - Regional Partnership Board	Limited	Director of Finance and Procurement	High	2.2	2.2We recommend that the Health Board ensures that consideration is given to amending the Accounts Payable FCP, to include reference to any bespoke purchase order process covering RPB funding processes. This should include possible payments in advance, referring to the requirements of the SFIs, Section 10.6, Prepayments, and the inclusion of funding to third parties on the basis of accrued costs.	2.2This will be reviewed and updated as required following the conclusion of sections 2.1, 2.3, 5.1 and 5.2.	31/08/2024	-4.00	31/12/2024	0.00		Completed/Closed	Completed/Closed	1				Revised arrangements include all payments in arrears unless specific extenuating circumstances are identified and uniquely approved by the RPB and ABUHB DoF (in line with ABUHB SFI's)	31/12/2024

Internal	2023.28	ABUHB Financial Controls - Regional Partnership Board	Limited	Director of Finance and Procurement	Medium	2.3.1	2.3.1 We recommend that the Health Board ensures that clarity is provided over the steps to be taken with any internal financial checks and the evidence retention required, to ensure Section 6.1 of the Accounts Payable Financial Control Procedure is adhered to.	2.3.1 Section 6.1 of the Accounts Payable Financial Control Procedure states that 'it is the responsibility of the requisitioner of goods and services to ensure that the correct financial code is inserted within the requisition.'	31/10/2024	-2.00		#VALUE!		Complete d/Closed	Complete d/Closed			August 2024: Draft Memorandum of Understanding is currently awaiting review by Corporate Governance and approval by ABUHB. Once finalised and agreed, the FCPs can be updated accordingly.			"The payment tracker has been enhanced to capture all details of each requisition, including the coding of the purchase requisition which is determined by the funding stream. The standard operating procedures have now been updated."	31/12/2024
Internal	2023.28	ABUHB Financial Controls - Regional Partnership Board	Limited	Director of Finance and Procurement	Medium	3.1	3.1 We recommend that the Health Board ensures that the Approval of Orders Greater than £100k FCP is updated for specific approval limits, to include reference to RPB payments and to reflect RPB funding type transactions.	The Health Board, led by the Director of Corporate Governance, is currently undertaking a review of the Scheme of Delegation, including specific approval limits. Once any amendments have been suggested and approved, by the appropriate Governance route, the Orders Greater than 100k FCP will subsequently be updated.	31/10/2024	-2.00		#VALUE!		Complete d/Closed	Complete d/Closed					Scheme of Delegation approved by Board in September 2023		31/12/2024
Internal	2023.28	ABUHB Financial Controls - Regional Partnership Board	Limited	Director of Finance and Procurement	Medium	3.2.2	3.2.2 We recommend that the Health Board ensures that the revisions to the authorised signatory list, regarding RPB payments, including the significant increases in the Chief Executive's delegated limits, are communicated to the Audit, Risk and Assurance Committee.	3.2.2The Director of Corporate Governance is currently undertaking a review of specific approval limits. Proposed amendments will be presented to the Board for approval in September 2024, pending further work on a comprehensive Financial and Non-Financial Scheme of Delegation.	31/03/2025	2.95		#VALUE!		Complete d/Closed	Complete d/Closed					Scheme of Delegation approved by Board in September 2024		31/12/2024
Internal	2023.28	ABUHB Financial Controls - Regional Partnership Board	Limited	Director of Finance and Procurement	Medium	3.3	3.3 We recommend that the Health Board ensures that consideration is given to potential conflicts of interest over commitments with the Chair of the Health Board.	The Health Board has a defined process for the handling and recording of conflicts of interest in place via the Standards of Business Conduct Policy with a reviewed Policy due to be presented to the Board for approval in September 2024. This would cover any conflicts that may/actually arise for the Health Board Chair. Conflicts of interests arising within the RPB Board's membership (including the Chair of the RPB), will need to be handled in-line with the RPB's governance framework and recorded through the RPB's host body arrangements (Torfaen County Borough Council). RPB funding will only be approved by the Health Board's Chair where there is prior RPB approval in place. There is no circumstance where the Chair has authority to approve RPB expenditure in isolation. In exceptional circumstances, the RPB Chair is able to take Urgent Chair's Action, in conjunction with other Statutory Partnership Bodies, and this process is defined within the RPB's Governance Framework.	03/03/2025	2.03		#VALUE!		Complete d/Closed	Complete d/Closed					Standards of Business Conduct Policy approved by Board in September 2024. RPB Governance Framework established.		31/12/2024
Internal	2023.28	ABUHB Financial Controls - Regional Partnership Board	Limited	Director of Finance and Procurement	Medium	3.2.1	3.2.1 We recommend that the Health Board ensures that the revisions to the authorised signatory list, regarding RPB payments, including the significant increases in the Chief Executive's delegated limits, are communicated to the Audit, Risk and Assurance Committee.	3.2.1Specific approval limits, including those in reference to RPB, are revised only when the appropriate Governance route has been completed and documented. Communication of any amendments would not be relevant for the Audit, Risk and Assurance Committee as the Board has reserved authority to approve its delegated financial limits.	31/10/2024	-2.00		#VALUE!		Complete d/Closed	Complete d/Closed					Scheme of Delegation approved by Board in September 2024		31/12/2024

Internal	2023.28	ABUHB Financial Controls - Regional Partnership Board	Limited	Director of Finance and Procurement	Medium	5.2	We recommend that the Health Board ensures that clarity is provided over the invoice and receipting process through to the service level expected for the prompt payment of invoices.	Currently, the receipting of a purchase order is driven by collective assurance provided by both the PMO and PMO Finance team, followed by approval from the Assistant Director Partnership & Integration or Deputy Director of Strategy, Planning & Partnerships. This can sometimes take more time if appropriate assurance is not provided by the receiving organisation and can lead to invoices being received prior to receipting taking place. This process is currently being reviewed to ensure that project assurance and delivery can be verified in a timely manner to avoid unnecessary delays to invoice payments.	31/10/2024	-2.00		#VALUE!		Complete d/Closed	Complete d/Closed					"Standard Operating Procedures have now been created for a number of areas covering both Requisitioning and the and the Payments and Receipting process."	31/12/2024	
Internal	2023.37	Newport East Health and Wellbeing Centre	Reasonable	Director of Public Health	Medium	1.1	The Project Board governance arrangements should be reviewed including: • The constitution and capacity of the Project Board to effectively execute its remit within the Health Board should be reviewed from a resource perspective (noting quoracy and attendance issues). • The agenda should be amended to formally include project finance as an agenda item All • Project Board minutes/action plans (as appropriate) should ensure that key scrutiny issues, decisions and approvals are detailed	Accepted The Terms of Refence for the Project Board have been updated to reflect changes in key personnel, with the final draft being presented to Project Board in October.The cancellation of the Project Board on the 6 March was anisolated occurrence and the Project Board has subsequently continued to meet as per the programme meeting schedule and quoracy.Standard agenda has now been amended to include finance as a formal agenda item Minutes will be reflective of key decision and actions and Action Logs will be completed and updated as part the Project Board discussions.	31/10/2024	-2.00		-1496.95		Complete d/Closed	Complete d/Closed			January 2025: As reflected in the Management Response, the Terms of Reference were updated and agreed in Project Board on the 23rd October 2024. The ongoing agenda also in Actions logs, and finance as a formal agenda item for discussion.				31/12/2024
Internal	2023.37	Newport East Health and Wellbeing Centre	Reasonable	Director of Public Health	Medium	2.1	Governance of the Community and Engagement Steering Group should reflect good practice including addressing the following issues: • The update of the Terms of Reference to reflect recent changes in roles and responsibilities of the Community and Engagement Steering Group. • The importance of Community and Engagement Steering Group attendance should be reiterated. Future meetings should be quorate and continue to meet regularly. • The Community and Engagement Steering Group should receive appropriate project progress reports to facilitate appropriate scrutiny and challenge.	Accepted During quarter 4 23/24 the Terms of Reference for the Communications and Engagement group were refreshed, and the Head of Corporate Communications also became a standing member of the group to provide support. This also ensured that all documentation such as the highlight reports went through the Communications and Engagement Group for both awareness and action where needed. The Communications and Engagement Group Report is also shared with other groups and Project Board to improve flow of information and decision making. Attendance at the Communication and Engagement Group has been raised to the Project Board and the Board is reaffirming the importance to all members that attendance is crucial.	31/10/2024	-2.00		-1496.95		Complete d/Closed	Complete d/Closed			January 2025: As updated in the Management Response, the Terms of Reference were updated and all the other recommendations have been actioned.				31/12/2024
Internal	2023.37	Newport East Health and Wellbeing Centre	Reasonable	Director of Public Health	Medium	4.1	The Project Board should receive regular progress updates against Gateway recommendations, clearly identifying any actions still outstanding.	Accepted Progress against the Gateway recommendations will be astanding agenda item for update and discussion at Project Board	31/10/2024	-2.00		-1496.95		Complete d/Closed	Complete d/Closed			January 2025: Discussions took place at Project Board with members noting the update and no issues were raised				31/12/2024
Internal	2023.37	Newport East Health and Wellbeing Centre	Reasonable	Director of Public Health	Low	9.1	The UHB should ensure the consistent and timely submission of KPI's, for all parties including Project Director and Supervisor.	Accepted The Health Board will ensure that KPI's are completed withintimely manner and will include the Supervisor scores. It is not practical however to include Project Director scores as they will be evaluating themselves. This score however will be provided by other partners within the project.	30/11/2024	-1.02		-1496.95		Complete d/Closed	Complete d/Closed			January 2025: KPI's are completed within a timely maner, including the supervisor scoring. The PD is scored by other parties but not by the HB as they would be reviewing themselves. There were no areas for concern or challenge.				31/12/2024

Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Low	R1	A formal SOP should be defined that sets out how the RPA process is to be managed. The operational service model should be fully defined and the terms of reference for the governance board reviewed and updated.	Upon successful investment case being made this will be addressed as part of the transition to service delivery	01/06/2023	-18.98	31/12/2024	0.00		Complete d/Closed	Complete d/Closed	4		"January 2025 The operational model for RPA has been completed. A monthly Service Management Board is in place. RPA will report through the new governance arrangements into the DDAT sub-committee"August 2024: Work on the delivery model has been delayed due to a focus on transitioning all existing automations onto a new BPC platform as part of essential maintenance work to secure a sustainable service. It is expected that the operational delivery model will be completed by the end of the calendar year. June 24 - the RPA posts have been filled, handover is complete from the contractor architect. The operational service model is being defined. Jan-24: RPA posts are in the Trac process for readvert and interview. A draft operational model has been developed. Completion remains dependent on successful team recruitment Nov 23: Unable to recruit necessary posts so investigating alternative options. Aug-23: 2 posts funded for a permanent team.Recruitment underway. Team will sit within Softwrae development as part of Integration services			The process for requesting, prioritising and delivering RPA has been completed. An operational model is in place. There are clear terms of reference for the RPA SMB	31/12/2024
Internal	2023.06	Estates Condition - Jan 2024	Limited	Director of Strategy, Planning & Partnerships	High	R5	The adequacy of the existing Capital Development & Estates workforce will be affirmed (in terms of capacity and associated skill sets required) and to inform a financial model for required revenuesupport.	Agreed - the Divisional Director will review the operational workforce required to manage the current level of reactive work and also to ensure compliance with the appropriate level of Planned and Preventative Maintenance (PPM).	31/05/2024	-7.02		-1496.95		Complete d/Closed	Complete d/Closed	2		January 2025: The analysis has been completed and at this stage no revenue case is being developed for consideration. The topic was presented as part of an update to Executive Committee and F&P committee on 'estates compliance' in December 2024 Aug 2024: Work remains ongoing to assess all the necessary detail and any proposals for consideration. At this stage the operation challenge focuses on recruiting to the existing vacancies. June 2024: Work is ongoing within the Division including the use of data analysis provided with external (no cost) support. Due to competing operational pressures for the estates function during year end capital pressures and normal winter challenges there has been a delay. A paper outlining the issues will be brought through to Executives in July 2024. The issue has however been discussed at the Division's Annual Review with Executives.				31/12/2024
Internal	2023.35	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Medium	6.1	A thorough reassessment of remaining project risks should be undertaken to update the risk register and confirm the remaining contingency requirements.	Agreed – a Risk Register Review will be undertaken and will ensure that it is updated to reflect the remaining contingency requirements.	31/10/2024	-2.00		-1496.95		Complete d/Closed	Complete d/Closed			January 2025: The Construction Risk Register reviewed on a bi-monthly basis with the contingency pots adjusted in line with identified risks. This is the reported through Project Team and Project Board with any key/ new risks highlighted.		Construction Risk Register continues to be reviewed as per contract requirements	31/12/2024	
Internal	2023.35	Development of a Regional Radiotherapy Satellite Centre at NHH	Reasonable	Director of Strategy, Planning & Partnerships	Medium	6.2	The Project Board should demonstrate ongoing scrutiny and management of the project risks (and available contingency funds) through to completion.	Agreed -once reviewed this will be discussed and scrutinised at the relevant Project Board.	31/10/2024	-2.00		-1496.95		Complete d/Closed	Complete d/Closed			January 2025: Project Risk Register reviewed on a regular basis and with detail discussed through Project Team and Project Board. All new and escalated issues are highlighted and relevant mitigating actions are put in place to manage the risk appropriately from both a service and wider project perspective.		Project Risk Register regularly reviewed with any new risks highlighted to Chair/ SRO ahead of Project Board including any relevant mitigation which can be put in place to manage risks.	31/12/2024	
Internal	2023	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	Medium	R1	A timeline plan for the path to the closure of the case should be prepared and shared with all persons involved in the case, in order that participants can plan and prepare for their input and schedule time to do so.	A review of the complaint process will be undertaken following the OCP process to realign Quality Patient Safety resources to the Nursing Directorate. A new Quality Patient Safety Manager has been appointed who will be responsible for the complaints process. Since period of review the PTR, Legal and QPS teams are aligning under one structure, this will bring together enhanced knowledge and skills of the PTR regulations, legal tests and required timelines. The new structure will triangulate the whole complaint process, bringing improved quality and timeliness to concern responses.	31/03/2024	-9.02		-1496.95		Complete d/Closed	Complete d/Closed	3		January 2025: A comprehensive review of the complaints process has been undertaken. A robust action plan with milestones for achievements has been developed. Acknowledgement team and communications standards launched. The QPS and complaints team are focusing on improving the quality of complaint responses, ensuring compassionate meaningful and timely investigations are undertaken. The Health Board is committed to reaching 75% compliance within WAG targets. Improved SOPs and governance procedures are being developed to underpin the changes. Twice weekly meetings are now in progress with the Head of QPS/Deputy Director of nursing. Weekly report shared with Director of Nursing. October 2024: October 2024: A comprehensive review of the complaints process has been undertaken. PALS service launched in November 2023 which has had a positive impact by facilitating early engagement with patients and families, addressing concerns and reducing escalation of complaints. The PTR policy has been updated to streamline process, provide clarity and improve efficiency. Acknowledgement team and communications standards launched. The QPS and complaints team are focusing on improving the quality of complaint responses, ensuring compassionate meaningful and timely investigations are undertaken. The Health Board is committed to reaching 75% compliance within WAG targets. March 2024: The OCP has now concluded on 9th February 2024. Centralising all PTR teams to ensure PTR regulations are adhered to. Trajectory has been devised for all divisions the Health Board has committed to be within the 75% Welsh Government target by September 2024.				31/12/2024

Internal	2023	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	High	R4	Current barriers that are leading to poor resolution target and compliance rates require identification and resolution urgently.	An urgent review of any immediate barriers and quick winds will be undertaken. The PALS service was launched in November which will aim to resolve more complaints through early engagement with families	31/12/2023	-12.00		-1496.95		Complete d/Closed	Complete d/Closed		January 2025: A new B7 concerns manager has been appointed with a focus around Early Resolution and acknowledgement to drive focus around timely and earlier resolutions for patients before entering the Managed Under PTR process. This will help in alleviating the pressures around formal complaint process management and compliance. June 2024: PALS team are now actioning all grade 1 and 2 concerns. 6 monthly evaluation report in progress. Closer liaison between PALS and PTR team. March 2024: The QPS resource centralised on 15th February 2024. We are in the process of reviewing and remapping the entire concerns pathway which will identify and address the barriers that are leading to poor compliance. The PALS service are now managing all grade 1 and 2 concerns.				31/12/2024



Aneurin Bevan University Health Board

Health Board Committee Assurance Note

Executive Lead		Paul Solloway, Director of Digital	
Reporting to:		Audit, Risk & Assurance (ARA) Committee	
Summary At a previous Committee meeting, it was requested that an assurance report would be produced on any recommendation requesting a revised deadline beyond the agreed threshold of two extensions. This assurance note provides the committee with more detailed information on the progress of the implementation of 5 recommendations from 2 audit reports that have exceeded the agreed threshold and are held by the Director of Digital.			
1. Audit Report Title: IM&T Control and Risk Assessment 2020/21 - Advisory			
Recommendation 6:		R6 Consideration should be given to the placement of all informatics provision and support across the Health Board. As part of this the current partially decentralised model should be re-assessed in terms of its suitability for the modern use of technology.	
Management Response:		Accepted. Following the exec review of the Target Operating Framework and overarching governance will appraise the hybrid environment of departmental asset ownership, responsibility, risk management. As the report sets out this is a largely historical and organic model which will be complex to resolve. A risk-based approach will be adopted, and an options paper will be developed for consideration by the Board.	
Number of Extensions requested * <i>including the current request</i>		4	Most recent requested extension date 31/12/2025
Update: As there are several areas where a “shadow IT” function is in operation, in conjunction with NWSSP Internal Audit it has been agreed that they will undertake a specific audit reviewing this across the Health Board. Once complete a paper with recommendations will be taken to the Executive Committee to agree the way forward.			
Recommendation 1:		R1 The governance framework for IM&T / digital should be clarified and where control over aspects of IM&T has devolved to departments, there should be a process for these to feed into the relevant Committee to ensure	

		oversight. Underneath the Committee the steering group remit and membership should be defined.	
Management Response:		Agreed. The Health Board is establishing a new governance framework. Currently Informatics is reporting to the Audit Committee, the first report is scheduled for 8th April. A Health Board governance framework is in development for informatics including exec oversight, investment and delivery. The management of the global pandemic has disrupted the planning work by 12 months, but this is now re initiated. Recommendations are scheduled to be presented to Exec Team Q1, and Board in Q2;	
Number of Extensions requested * <i>including the current request</i>	7	Most recent requested extension date	31/03/2024
Update: The governance structure for digital has now been developed and all groups are in place apart from the Digital, Data & Technology Sub-Committee. The terms of reference have been drafted and are currently under review but in the interim reporting to the Finance & Performance Committee and the Partnerships, Population Health & Planning Committee is in place. This meeting will be in place by the 1st April 2025 following approval at Executive Committee. Governance structure is below: Digital Data & Technology Governance			
Recommendation 9:		R9 A network of champions across the organisation should be established. The Digital Strategy should be re-issued alongside the roadmap. This should form the basis for engaging the network of champions to drive the Strategy forward.	
Management Response:		Accepted-The Channel 3 report also identified a need for more emphasis on Clinical Leadership, Design and Business Partnering. This is subject to additional investment although recently the appointment of a full time CNIO/CSO has been a significant step forward. Out with the Directorate recommendations will be presented to Execs on overarching exec level oversight which is intended to both strengthen accountability but also to ensure Informatics capacity is used to best effect. Benefits realisation training has commenced in Informatics and will form part of reporting. It is in principle agreed that the Health Board adopts a single methodology and framework that should be co-produced to manage all priority investments.	
Number of Extensions requested * <i>including the current request</i>	5	Most recent requested extension date	30/09/2025

Update:

Some progress has been made with the Digital Clinical Council now reformed reporting into the Health Board's governance structure and digital engagement meetings now held with all divisions.

Strategy development has commenced and will be aligned to the forthcoming Health Boards 10-year strategy.

Clinical engagement workshop is being held on the 10th February and following this a paper will be taken to the Executive Committee on the future way forward for clinical engagement and leadership.

Digital champions are in place for Microsoft 365 and a Centre of Excellence is being created for Data & Analytics.

2. Audit Report Title: **IT Strategy**

Recommendation 2:	The role of the CCIO and CNIO should be fully defined.		
Management Response:	2.1a The CCIO currently has an AMD role profile. There have been discussions for some time in terms of role design and accountability with the CCIO MD CEO and CDO. A model role profile based on the Faculty of Clinical Informatics example has been agreed and is now being localised. The CNIO has a full role profile and agreed Job description		
Number of Extensions requested * <i>including the current request</i>	3	Most recent requested extension date	30/04/2025

Update:

Clinical engagement workshop is being held on the 10th February and following this a paper will be taken to the Executive Committee on the future way forward for the CNIO and CCIO roles aligned to the Federation of Informatics Professionals role profiles.

Recommendation 3:	Leads within divisions should be established to work with the CCIO / CNIO		
Management Response:	The principle of Divisional Leads is accepted by the health board. The proposition now needs to be explored and defined in a proposal by the CCIO and CNIO to the Digital Delivery Oversight Board.		
Number of Extensions requested * <i>including the current request</i>	3	Most recent requested extension date	30/04/2025

Update:

Clinical engagement workshop is being held on the 10th February and following this a paper will be taken to the Executive Committee on the future way forward for the CNIO and CCIO roles aligned to the Federation of Informatics Professionals role profiles which will include clinical engagement across the divisions.

Executive Lead		Leanne Watkins, Chief Operating Officer	
Reporting to:		Audit, Risk & Assurance (ARA) Committee	
Summary			
At a previous Committee meeting, it was requested that an assurance report would be produced on any recommendation requesting a revised deadline beyond the agreed threshold of two extensions.			
This assurance note provides the committee with more detailed information on the progress of the implementation of 1 recommendation from 1 audit report that have exceeded the agreed threshold and are held by the Chief Operating Officer.			
3. Audit Report Title: Tredegar Health & Wellbeing Centre 2023			
Recommendation 4:		Management should obtain signed lease agreements with relevant parties at the earliest opportunity	
Management Response:		Agreed. The provision of signed lease is being actively addressed so that they are in place well before the planned occupation of the building.	
Number of Extensions requested * including the current request		4	Most recent requested extension date 31/03/2025
Update:			
The main issue is actually not the lease documents but the lack of agreement around the service charges which as a ‘landlord’ the Health Board will charge each tenant to cover costs for the building including rates, utilities, cleaning and general maintenance.			
The HB has calculated the costs of the service charges by dividing the Demise Internal Area that the tenant occupies by the total exclusively occupied/lettable Net Internal Area (NIA) of the building to arrive at a percentage occupation.			
As an illustration, Total exclusively occupied/lettable NIA of the property: 1,500 square metres Occupier’s Net Internal Area (NIA): - 250 square metres Percentage of occupation: 250 / 1,500 x 100 = 16.67% A map of the site is provided below			
 FINAL AGREED UpperGroundFloorL			
In this illustration above the occupier would be charged for 16.67% of the total service charges for the property and the remainder will be apportioned to the other occupiers of the property according to their calculated %.			
The % of the occupied area is then also translated to assess their liable portion of any shared areas (walkways, waiting rooms, toilets, break rooms etc) which are within the building.			

Facilities management charges (i.e service charges) are calculated based on direct usage of services. All the contractors have been approached, unfortunately all four have declined to sign, whilst waiting for a service charge figure.

The new building is occupied by ABUHB, one Dental contractor, two GMS practices and a pharmacy therefore a high portion of the costs are associated with independent contractors in occupation of the building. The view of the contractors are that the accurate costs of service charge post occupation (and the issue of their shared responsibility for the service charge for shared areas) is much higher than previously discussed with the Health Board and a significant financial challenge.

Contractors

Tredegar Practice

- Heads of terms and leases are with the Practice waiting signature of tenant and Health Board. The service charge being the main issue to progressing the lease. At the time of the initial occupation of the building in January 2024, this practice was in fact a Health Board managed practice.

Glan Yr Afon Practice

- Heads of terms and leases are with the Practice waiting signature of tenant and HB. The service charge being the main issue to progressing the lease.
- For this practice a review of the previously agreed schedule of accommodation (SOA) has been conducted by NHS Wales Shared Estates Services (SES) based on patient numbers and need as there was a view that some rooms allocated to them which were not required. This work has been undertaken and is being discussed with the practice. If the practice is satisfied with the findings and do not wish to relinquish space then the detail of the draft lease will remain unchanged.

Dentist

- The Health Board are waiting on SES advice on the reimbursement of dental chairs which is connected to the rental costs. Contractor has advised they will purchase the replacement for the chairs at end of life. This will allow a reduction in rent making it more palatable for the Contractor to sign.
- As the with the GMS providers the service charge issue is also a delay for the Dental contractor.

Pharmacy

- The Pharmacy are resistant to sign the lease without the GMS element not signing. The lack of GMS lease has been added as a break within the Pharmacy lease but they are still hesitant. The issue with the service charge has rendered this a secondary issue, it is believed that once the service charge has been agreed the Pharmacy will sign.
- As the with the GMS providers the service charge issue is also a hindrance to sign the lease.

Work is active with all parties and the content of the lease is concluded and in effect agreed. The delay remains the agreement of a service charge for the occupation and the differing views of apportionment of the costs associated with the shared areas.

Executive Lead	Jennifer Winslade, Director of Nursing
Reporting to:	Audit, Risk & Assurance (ARA) Committee
Summary	

At a previous Committee meeting, it was requested that an assurance report would be produced on any recommendation requesting a revised deadline beyond the agreed threshold of two extensions.

This assurance note provides the committee with more detailed information on the progress of the implementation of **2** recommendations from **2** audit reports that have exceeded the agreed threshold and are held by the Director of Nursing.

1. Audit Report Title: **Monitoring Action Plans 2022**

Recommendation 2:	Management should review the number of actions raised within the HIW reports and the number of actions noted within the reports sent to committees for accuracy. Management should ensure no actions have been missed from the HIW report		
Management Response:	The Health Board agrees with this recommendation. An update to the SOP will be developed to ensure a Quality Assurance check is undertaken, confirming that all actions have been captured and referenced		
Number of Extensions requested * <i>including the current request</i>	4	Most recent requested extension date	31/03/2025

Update:

2. Audit Report Title: **Structured Assessment 2022**

Recommendation 3:	There is limited use of patient and staff stories at Board. The Health Board should consider how it can increase and maximise the benefit of patient and staff stories in Board and committees to help centre and focus meetings on the things that matter most, and to help triangulate this intelligence with formal agenda items.		
Management Response:	A Digital Story Protocol for staff and patient stories is currently under development and once approved an electronic digital repository of stories will be created. Digital Story Telling training has been commissioned. The CIVICA Citizen Feedback System now allows people to leave narrated stories. A selection of these will be played at the start of every Board meeting. The Executive Team will agree a programme of staff and patient stories that help triangulate intelligence with formal agenda items.		
Number of Extensions requested * <i>including the current request</i>	3	Most recent requested extension date	31/03/2025

Update:

- A number of digital stories have been made and there are a number in progress. These are presented via various forums including Board and at learning events.
- A new consent form has been developed and a version is now included in the digital story to ensure governance and compliance with GDPR.

This recommendation is outstanding due to the following: -

- Digital Toolkit will be concluded by the end of March 2025. This will be available on the Patient Experience and Involvement intranet page.

Aneurin Bevan University Health Board

Health Board Committee Assurance Note

Executive Lead		Jennifer Winslade, Director of Nursing		
Reporting to:		Audit, Risk & Assurance (ARA) Committee		
Summary				
At a previous Committee meeting, it was requested that an additional progress report would be produced on any outstanding recommendations relating to the Discharge Planning 2022 Audit.				
At the end of Quarter 4 (Reporting Period 1 st October 2024 – 31 st December 2024) there were 5 outstanding recommendations from the 2022 Discharge Planning Audit. Following review 2 of the 5 have been completed and the remaining 3 are in progress with an aim to complete by the end of March 2025, further details are provided below;				
R 3.1	R.3.3	R 4.3	R 5	R 7
1. Audit Report Title: Discharge Planning 2022				
Recommendation 3.1:		All patient discharges from the care of the Health Board are effectively controlled and evidenced by issuing a timely, completed discharge notification.		
Management Response:		The Medical Director is aware that the timeliness of some discharge notifications needs to be improved. A letter was sent to all medical staff outlining their responsibilities in respect of timely discharge notifications in 2021. This is now being followed up by the Assistant Medical Director for Planning who will be leading a task & finish group to develop standardisation of approach. This work will aim to ensure that patients are able to leave hospital with their discharge summary / notification and ensure it will be sent electronically to the GP on the same day		
Status:		Ongoing		
CWS technical change to be completed by end of quarter 4, 'perfect week' to be delivered in January/February, linking with Divisions and operational teams, standardised approach to be complete end of March 2025				
Recommendation 3.3:		A consistent discharge approach is adopted for all day care appointments and for inpatient transfers between Health Board sites		

Management Response:	In respect of day care episodes of care, there are many diagnostic / treatment areas and specialities who have different methods of notifying both the GP and patient of the care episode. We acknowledge that this is not a standard approach with some departments combining the clinical details as the discharge summary. As part of the Task and Finish group, the Assistant Medical Director for planning will ensure that discharge notifications form part of the standardised approach. For inter-site transfers an SBAR is completed for every patient that outlines the patient's condition, diagnosis and any actions needed to be taken by the receiving site.
Status:	Ongoing
New SBAR/step down process rolled out w/c 6th January, review of new process at regular interval to flag any areas of concern, update at Integrated Discharge Board on 28th January, survey to staff at 3/6 months to evaluate the new process. Assistant Medical Director to focus on ensuring that discharge notifications form part of standardised approach through pilot of 'perfect week' in January/February with completion of a standardised approach end of March 2025	
Recommendation 4.3:	A method for identifying delays during the discharges of 'simple' cases should be introduced, monitored and reported
Management Response:	Discharge delays can affect both simple and complex discharges and therefore emphasis should be improving the process for all patients. Length of stay data is available to explore the feasibility and the benefits of such an approach. The Health Board continually seeks to identify the factors that delayed discharge and this work forms part of the workstream for goal 5 of the Welsh Government '6 Goals for Urgent and Emergency Care' programme. As part of this programme, the Delivery Unit has recently released the 'optimal patient flow framework', and the Health Board will be embedding these principles as 'business as usual'. The framework will also feature in the new All Wales Discharge Policy, to include the introduction of the SAFER principles, D2RA and 'red & green days. These concepts have the potential to reduce LOS and improve discharge planning, so will be embedded within our policy.
Status:	Completed
Roll out of CWS2 across all wards and sites to support the recording of data which includes D2RA pathway, Red to Green days, reason for delay and clinically	

optimised status aligned to the 'Optimal Hospital Flow Framework'. Development of ward dashboards to assist operational staff with identifying reasons for delayed discharge and support with timely discharge planning. Ongoing monitoring re compliance, training and education to improve patient flow and deliver timely pathways of care	
Recommendation 5:	Determining whether to make the use of the discharge checklist mandatory (including which aspects to include) or not and if so, the document should be consistently completed. Performance should be monitored until fully embedded.
Management Response:	Discharge checklists are used by most wards; however, we acknowledge there is an inconsistent approach in their use. The Welsh Nursing Care Record is currently being rolled out across the Health Board and may provide the opportunity to make the checklist part of the digital record as part of a standardised approach. In the interim, the use of checklists will be reviewed as part of the Discharge Improvement Board workstreams. The use of checklists will be further defined in the new discharge policy.
Status:	Completed
Discharge Champions appointed - rolling programme of teaching sessions in place. WNCR rolled out across the HB - discharge checklist features within this. Further work being led nationally to refine with a lead in time of circa 1 year.	
Recommendation 7:	We recommend that the Health Board continue to analyse the reasons behind re-admissions within a suitable period of time. Where themes and trends are identified that these are investigated further
Management Response:	The analysis of readmission rates is acknowledged as being problematic, as without clinical input at the time of readmission, our current systems are unable to differentiate between a readmission for a reason connected to a prior episode of care, or one that relates to a completely different clinical scenario. CHKS, which is the national benchmarking solution choice for Wales looks at the number of patients who have been readmitted regardless of specialty, consultant, diagnosis etc. This makes any analysis difficult to interpret or perhaps meaningless. The planning department is currently working with clinical teams to develop a number of meaningful measures to determine and understand readmission trends, and to identify where improvement is required. A number of data viewers have been developed and can provide 'bespoke' data by request. Moving forward, these measures will be

	included within the outcome measures and QPS insights. The Health Board has dedicated services to address frequent or 'high impact' service users that are working across Divisional Boundaries to provide alternative pathways. There is also a workstream focusing on patients at high risk of readmission supported by Lightfoot data and linked to goals 1 and 2 of the 6 Goals for Urgent & Emergency Care programme.
Status:	Ongoing
Readmission rates to be monitored as part of the optimal ward model, across three wards at RGH, Medicine, Community and Surgical, identifying reason for readmission aligned to the 50-Day Integrated Care Winter Challenge. Enhanced resource in Corporate Performance team to support analysis of discharge data and information. Optimal ward model to commence 6th January with an evaluation point at end of March 2025	

DYDDIAD Y CYFARFOD: DATE OF MEETING:	18 February 2025
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Financial governance, reporting & control.
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Robert Holcombe, Director of Finance, Procurement and Value Based HealthCare
SWYDDOG ADRODD: REPORTING OFFICER:	Mark Ross, Assistant Finance Director

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

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

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

The Audit, Risk and Assurance Committee is requested to:

- Note the contents of this report.
- Approve the updated financial control policy and procedures.
- Counter Fraud Bribery and Corruption Policy (Appendix 1)



Cefndir / Background

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

The FCPs presented were considered and approved by the Executive Committee at their meeting on the 30th of January and are presented to the Audit, Risk and Assurance Committee for approval.

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

Asesiad / Assessment

1.Financial Control Procedures (FCP)

Financial Control Procedures are reviewed, as a minimum, on a 3 yearly basis.

The following Counter Fraud FCPs have been reviewed:

- Counter Fraud Bribery and Corruption Policy
- Counter Fraud and Workforce & OD Joint Working Protocol
- Counter Fraud and Internal Audit Joint Working Protocol
- Counter Fraud Communication Strategy

Following an extensive review, all of the documents have been collated into the following procedure to aid ease of access and knowledge sharing:

- Counter Fraud Bribery and Corruption Policy (Appendix 1)

A summary of the main changes to the Financial Control policy is set out below. The full revised FCP is included in Appendix 1.

Counter Fraud Bribery and Corruption Policy

Owner: Director of Finance, Procurement and Value
Review Date: November 25

It is the Health Board's basic principle to ensure the proper use of public funds. It is therefore important that all staff, including secondees, are aware of the risk of fraud; means of combatting it and other illegal acts involving dishonesty that cause financial loss to the organisation.

The procedure aims to improve knowledge and understanding about the risk of fraud, bribery and corruption within the Health Board; promote a climate of openness and set out responsibilities in terms of deterrence, prevention, detection and investigation.

The document has been circulated for comment as follows:

- Head of Human Resources
- Director of Workforce & OD



- NWSSP - Audit and Assurance Services
- Director of Finance & Assistant Finance Directors

Main changes to the document

Paragraph	Summary of change
3	Policy Statement – sentence added to explain that ‘no employee will suffer in any way as a result of reporting reasonably held suspicions’
9	Counter Fraud Response Plan – Online reporting form and Counter Fraud intranet pages links updated
11	Communication with Media - section added to combine the Counter Fraud Bribery and Corruption policy and separate Counter Fraud Communication Strategy
Appendices 1 to 5	Flowcharts - updated to reflect current terminology; desktop guide removed as no longer relevant; fraud referral form removed as no longer relevant
Appendix 5	Counter Fraud and Workforce & OD Joint Working Protocol – appendix added to combine the Counter Fraud Bribery and Corruption policy and separate Counter Fraud and Workforce & OD Joint Working Protocol <u>Main Changes:</u> • 1.3 Introduction - paragraph added to highlight that the ‘organisation has a duty of care to the individual/s involved in investigations and the impact that this can have’ • 2.4 Witness Statements - clarification paragraph added in relation to witness statements and support provided • 2.6 Investigation Closure Report - clarification paragraph added in relation to purpose and distribution of report ie flagging risks to divisions • 4 The Liaison Process - clarification of process in relation to Executive Lead being informed of investigations and outcome • 5 Associated Documents - link to intranet policies page added
Appendix 6	Counter Fraud and Internal Audit Joint Working Protocol – appendix added to combine the Counter Fraud Bribery and Corruption policy and separate Counter Fraud and Internal Audit Joint Working Protocol

Summary Position on Financial Control Procedures



- 2024-25 Discount rates for general provisions, post-employment benefits, financial instruments, and leases (under IFRS16) – announcement of rates. The new discount rates have already been applied to the relevant provisions and the impact reflected in the 2024-25 financial position.
- IFRS 17 Review Guidance
Notification of the submission requirements for the review of IFRS 17. The requirements have been circulated to the appropriate employees for completion.
- Disclosure of Senior Managers’ Remuneration (Greenbury) 2024-25
The list of names required for the senior manager remuneration report will be requested from the pension’s agency in accordance with the timetable provided.

The 2024-25 draft Manual for Accounts was also issued by Welsh Government on the 17th of December 2024. The draft manual has been reviewed internally, with comments and clarifications sent back to Welsh Government by the deadline.

3. Key Dates for the Annual Accounts 2024-25

The main deadlines, proposed Audit Committee review and Board approval dates are shown in the following table.

The dates are based on the initial timescales from Welsh Government and are potentially subject to change. They are expected to be finalised in early February.

Provisional Annual Accounts & Report 2024/25 - Key Dates	2025	
First draft Performance Report and Accountability Report for consideration by Exec Team	Thur	01-May
Unaudited accounts and associated returns to WG	Fri	02-May noon
Draft Performance Report Overview, Accountability Report and Remuneration Report to WG	Fri	09-May noon
Draft Reports to Audit Committee Members	Tue	13-May
Audit, Risk & Assurance Committee meeting to Consider Draft Accounts and Draft Accountability Report	Tue	20-May
Final Accounts & Accountability Report to Audit Committee Members	Tue	17-Jun
Audit, Risk & Assurance Committee meeting to Consider Final Accounts, and Accountability Report	Tue	24-Jun



Board meeting to approve Final Accounts and Accountability Report	Wed	25-Jun
Final Annual Report Deadline for Submission to WG – Annual Report and Accounts as a single unified document	Thur	30-Jun noon
Annual General Meeting – to receive the Annual Report and Accounts		TBC

4. Public Sector Payment Policy (PSPP)

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

Category	Invoices	In Mth %	YTD %
NHS	Value	98.5	97.6
	Number	88.2	90.9
Non-NHS	Value	97.6	96.4
	Number	98.5	97.8

The Health Board has achieved the target to pay 95% of the number of non-NHS creditors within 30 days of delivery of goods/services in September and cumulatively.

Whilst there has been a small decrease in the number of NHS invoices paid within 30 days this month there is significant improvement over last year when it was well below 90%.

As part of their reporting of key performance indicators (KPIs), NHS Wales Shared Services Partnership (NWSSP), have shared the all-Wales statistics on PSPP performance up to the end of December 2024. The below tables show that Aneurin Bevan currently have the best PSPP percentages against other Health Boards for both NHS and Non-NHS by the number of invoices processed.

Invoice	Health Board	In Mth %	YTD %
NHS by Number	Aneurin Bevan UHB	88.2	90.9
	Betsi Cadwaladr UHB	91.9	88.0
	Cardiff & Vale UHB	88.7	88.2
	Cwm Taf Morgannwg UHB	76.2	81.1
	Hywel Dda UHB	88.3	86.8
	Swansea Bay UHB	73.3	84.9
Non-NHS by Number	Aneurin Bevan UHB	98.5	97.8
	Betsi Cadwaladr UHB	97.6	95.7
	Cardiff & Vale UHB	96.3	97.4
	Cwm Taf Morgannwg UHB	97.2	96.1
	Hywel Dda UHB	97.8	96.4
	Swansea Bay UHB	96.4	96.1



5. Payments in Excess of £100K

There were no exceptional issues to report.

6. Standing Financial Instructions

There is no update on the standing financial instructions (SFIs), however we have been notified by Welsh Government that they will updating the SFIs in 2025-26, with a revised section in relation to the updated Procurement Act.

Argymhelliad / Recommendation

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

- Counter Fraud Bribery and Corruption Policy (Appendix 1)

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	Improve the Wellbeing and engagement of our staff 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 PSPP – Public Sector Payment Policy NWSSP – NHS Wales Shared Services Partnership KPI – Key Performance Indicators SFI – Standing Financial Instructions
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:	Is EIA Required and included with this paper? A resource assessment is required to support decision making by the Board and/or Executive Committee, including policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following: Not Applicable Yes, outlined within the paper Yes, outlined within the paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working	Choose an item. Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives





Counter Fraud, Bribery and Corruption Policy

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

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1. Executive Summary

One of the basic principles of public sector organisations is the proper use of public funds. It is therefore important that all those who work in the public sector are aware of the risk of fraud and the means of combatting it and other illegal acts involving dishonesty that cause financial loss to the organisation. For simplicity all such offences are hereafter referred to as “fraud”, except where the context indicates otherwise. This document sets out the Aneurin Bevan University Health Board (ABUHB) policy and response plan for detected or suspected fraud.

On the 1st of November 2017, NHS Counter Fraud Authority (NHSCFA) was created. This was achieved under amendment from the UK Government Secretary of State for Health. The previous arrangements which Welsh Ministers entered into with the predecessor organisation of the NHSCFA, which was pursuant to section 83 of the Government of Wales Act 2006, were reviewed and remained effective with the NHSCFA.

NHSCFA has national responsibility for all policy, operational and training matters relating to the prevention, detection and investigation of fraud, bribery and corruption in the NHS. NHSCFA also provides advice, guidance and risk measurement to NHS Bodies in Wales on all aspects of fraud, bribery and corruption. All instances where fraud is suspected are properly investigated, until their conclusion, by staff who are fully trained and accredited and who are duly nominated by NHSCFA.

ABUHB is committed to assisting in the reduction of the level of fraud, bribery and corruption within the organisation and the wider NHS to an absolute minimum and keeping it at that level, freeing up public resources for better patient care. This policy has been produced by the Local Counter Fraud Specialist (LCFS) and is intended as a guide for all employees on counter fraud work within ABUHB and the wider NHS. All

genuine suspicions of fraud, bribery and corruption can be reported to the LCFS or through the NHS Fraud and Corruption Reporting Line or the online reporting tool.

2. Aims

The overall aims of this policy are to:

- improve the knowledge and understanding of everyone in ABUHB irrespective of their position, about the risk of fraud, bribery and corruption within the organisation.
- assist in promoting a climate of openness and a culture and environment whereby staff feel able to raise concerns.
- set out ABUHB's responsibilities in terms of the deterrence, prevention, detection and investigation of fraud, bribery and corruption.
- ensure the appropriate sanctions are considered following an investigation, which may include any or all of the following:
 - criminal prosecution
 - civil prosecution
 - internal disciplinary action
 - professional regulation

3. Policy Statement

ABUHB is absolutely committed to maintaining an honest, open, and well- intentioned atmosphere within the organisation. It is also committed to the elimination of any fraud within ABUHB, and to the rigorous investigation of all such cases.

ABUHB wishes to encourage anyone having reasonable suspicions of fraud to report them. Therefore, it is also ABUHB policy, which will be rigorously enforced, that no employee will suffer in any way as a result of reporting reasonably held suspicions.

All members of staff can therefore be confident that they will not suffer in any way as a result of reporting reasonably held suspicions of fraud. For these purposes “reasonably held suspicions” shall mean any suspicions other than those which are raised maliciously and found to be groundless.

4. Scope of policy

This policy relates to all forms of fraud, bribery and corruption and is intended to provide direction and assist employees, who may have such suspicions. It provides a framework for responding to suspicions, advice and information on various aspects of fraud and the implications of an investigation. It is not intended to provide a comprehensive approach to preventing and detecting fraud, bribery and corruption. This policy is aligned to Government Functional Standard - 013: Counter Fraud and the 12 components/requirements stipulated therein.

This policy applies to all ABUHB staff, including secondees, those engaged via the bank, volunteers, those with honorary contracts, Independent Members, those working in bodies hosted by ABUHB and other parties who may have a business relationship with ABUHB. It will be brought to the attention of all employees and form part of the induction process for new staff.

The existence of this policy will support the organisation to operate within a clear and robust risk-based framework. It has been designed to achieve successful delivery of the Counter Fraud provision in a manner that:

- Upholds organisational values and standards of behaviour.
- Complies with all relevant regulatory, accreditation and licensing requirements, standards, directions and instructions.
- Secures the efficient, effective and economic use of resources.
- Safeguards and protects all assets, including its people.
- Ensures good governance when working in partnership with others.

5. Provisions of Government Functional Standard GovS 013 Counter Fraud

From April 2021, all NHS funded services nationally, were required to provide assurance of compliance with the requirements of the Functional Standard. This included NHS bodies in Wales.

The purpose of the Functional Standard is to set the expectations for the management of fraud, bribery and corruption risk in government organisations and wider public services, while reinforcing the government's commitment to fighting fraud against the public sector.

Complying with the Government Functional Standard - 013: Counter Fraud requires a three-stage framework to Counter Fraud work as outlined below:

- Strategic governance – This sets out the standards in relation to the organisation's strategic governance arrangements. The aim is to ensure that counter fraud measures are embedded at all levels across the organisation.
- Proactive response – This sets out the requirements in relation to raising awareness of NHS fraud across the organisation and working with NHS staff, stakeholders and the public to highlight the risks and consequences of economic crime against the NHS. This response also sets out the requirement in relation to fraud risk assessment and proactive initiatives with the aim of providing remedy and fraud proofing by ensuring that opportunities for fraud to occur is minimised/mitigated/disrupted.

- Reactive response – This sets out the requirements in relation to detecting and investigating crime, prosecuting those who have committed such crimes and seeking financial redress where appropriate.

6. Fraud, Bribery, Corruption and other related Offences

6.1. Fraud

The Fraud Act 2006 was introduced on the 15th of January 2007 and is focused on the dishonest behaviour of the suspect and their intent to make a gain or cause a loss. It includes the following offences that could be committed against the NHS:

- Fraud by false representation (s.2) – dishonestly misrepresenting something using any means, e.g. by words or actions.
- Fraud by failing to disclose information (s.3) – not saying something where there is a legal duty to do so.
- Fraud by abuse of a position of trust (s.4) – abusing a position where there is an expectation to safeguard the financial interests of another person or organisation.
- Possession of articles for use in fraud (s.6) – Having possession or control over a document or item, intended for use in the commission of fraud.
- Making or supplying articles for use in fraud (s.7) – Making, adapting, or supplying a document or item in the knowledge it is to be used to commit fraud.

It should be noted that all offences under the Fraud Act 2006 occur where the act or omission is committed dishonestly and with intent to cause gain or loss. The gain or loss does not have to succeed, the mere exposure to the risk of loss is sufficient, so long as the intent is there.

6.2. Other Offences

Outside of the Fraud Act 2006, the following offences could be committed against the NHS: (this is not an exhaustive list)

- False accounting (s.17 Theft Act 1968) – Dishonestly altering a record kept for accounting purposes in order to make a gain or loss.
- Possession of false identity documents (s.25 – Identity Cards Act 2006) Having possession or control over an identity document that is false, has been improperly obtained or relates to someone else.
- Unauthorised access to computer material (s.1 – Computer Misuse Act 1990) to secure access to a program or data that is unauthorised.
- Unauthorised access with intent to commit or facilitate commission of further offences (s.2 – Computer Misuse Act 1990) to carry out s1 with intent to commit an offence or facilitate to commission of an offence.
- Theft (s.1 – Theft Act 1968) to dishonestly appropriate, property that belongs to another with the intention of permanently depriving the other person of that property.
- Forgery and Counterfeiting Act 1981 (s.1 to s.4) making, copying, using or using a copy of a false instrument with the intention of inducing somebody to accept it as genuine.

6.3. Bribery and Corruption

Corruption can be broadly defined as the offering or acceptance of inducements, gifts, favours, payment, or benefit-in-kind which may influence the action of any person. Corruption does not always result in a loss. The corrupt person may not benefit directly from their deeds; however, they may be unreasonably using their position to give some advantage to another. It is a common law offence of corruption to bribe the holder of a public office and it is similarly an offence for the office holder to accept a bribe.

The Bribery Act 2010 received Royal Assent on 8th April 2010 and came into force on 1st July 2011. The Bribery Act 2010 provided 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”. It increased the maximum penalty for bribery 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 the company or organisation in question.

7. Public Service Values

The Codes of Conduct and Accountability for NHS Boards and NHS managers set out the key public service values. They state that public service values must be at the heart of the National Health Service. High standards of corporate and personal conduct based on recognition that patients come first, have been a requirement throughout the NHS since its inception. Moreover, since the NHS in Wales is publicly funded, it must be accountable to the Welsh Parliament for the services it provides and for the efficient, effective and economical use of taxpayers’ money.

There are seven principles of public life (The Nolan Principles). These general principles of conduct, which underpin public life, were restated when the Nolan Committee’s ‘First Report on Standards in Public Life’ was published in May 1995. These principles state that public officials should:

Selflessness:	Take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefit for themselves, their family, or their friends.
Integrity:	Not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in their performance or their official duties.
Objectivity:	In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards or benefits, choices should be made on merit.

Accountability:	Be accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
Openness:	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.
Honesty:	Have a duty to declare any private interest relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest,
Leadership:	Promote and support these principles by leadership and example.

The code also incorporates the following three crucial public service values which must underpin the work of the health service in Wales.

Accountability

Everything done by those who work in the NHS in Wales must be able to stand the tests of scrutiny by the Assembly, public judgements on propriety and professional codes of conduct.

Probity

There should be an absolute standard of honesty in dealing with the assets of the NHS in Wales; integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of the duties of the NHS in Wales.

Openness

There should be sufficient transparency about the NHS in Wales's activities to promote confidence between the NHS body and its staff, patients and the public.

All staff should be aware of and act in accordance with these values.

8. Roles and Responsibilities

This section states the roles and responsibilities of the organisation, employees and other relevant parties in reporting and mitigating fraud, bribery and corruption or other irregularities.

Aneurin Bevan University Health Board

ABUHB will take all necessary steps to counter fraud, bribery and corruption in accordance with this policy, current legal directions, the NHS Counter Fraud, Bribery and Corruption Manual, the policy statement '[Applying Appropriate Sanctions Consistently](#)' published by NHSCFA and any other relevant guidance or advice issued by that organisation.

The organisation has a duty to ensure that it provides a secure environment in which to work, and one where people are confident to raise concerns without worrying that it will reflect badly on them. This extends to ensuring that staff feel protected when carrying out their official duties and are not placed in a vulnerable position. If staff have concerns about any procedures or processes that they are asked to be involved in, the organisation has a duty to ensure that those concerns are listened to and addressed. The organisation must appoint a Local Counter Fraud Specialist (LCFS) that is accredited and nominated by the NHSCFA.

These steps to counter fraud, bribery and corruption will be in accordance with the provisions of Government Functional Standard GovS 013 Counter Fraud and should incorporate the three key principles outlined below. A key element in achieving this is the appointment of an LCFS.

Chief Executive

The Chief Executive is liable to be called to account for specific failures in the health board's system of internal controls. However, responsibility for the operation and maintenance of controls falls directly to line managers and requires the involvement

of all employees. ABUHB has a duty to ensure employees who are involved in or who are managing internal control systems receive adequate training and support in order to carry out their responsibilities. Therefore, the Chief Executive and Director of Finance will monitor and ensure compliance with this policy.

Director of Finance, Procurement & Value

The Director of Finance, Procurement & Value has overall responsibility for the Counter Fraud provision within the organisation. The Director of Finance, Procurement & Value in conjunction with the LCFS, monitors and ensures compliance with the Government Counter Fraud Directions – NHS Requirements. The Director of Finance, Procurement & Value will, in conjunction with the LCFS, inform appropriate senior management accordingly where suspicions of fraud arise.

The Director of Finance, Procurement & Value in liaison with the LCFS will consider the need to inform third- parties such as external audit or the police if circumstances dictate.

The Director of Finance, Procurement & Value will consider the need to inform and consult the Chief Executive in cases where the loss may be high or where the incident may lead to adverse publicity or reputational damage.

The Director of Finance, Procurement & Value or the LCFS will liaise with Workforce and OD (WOD), if a member of staff is to be investigated by the Counter Fraud department. The Director of Finance, Procurement & Value or LCFS will not conduct a disciplinary investigation, but the employee may be the subject of a separate investigation as part of a disciplinary process.

Managers

Managers must be vigilant and ensure that procedures to guard against fraud, bribery and corruption are followed. They should be alert to the possibility that unusual events or transactions could be symptoms of fraud, bribery and corruption. If they have any doubts, they must seek advice from the nominated LCFS.

Managers must instil and encourage an anti-fraud and anti-bribery and corruption culture within their team and ensure that information on procedures is made available

to all employees. (The LCFS will proactively assist the encouragement of an anti-fraud culture by undertaking work that will raise fraud awareness).

All instances of actual or suspected fraud, bribery or corruption which come to the attention of a manager must be reported immediately. It is appreciated that some employees will initially raise concerns with their manager. However, in such cases, managers must not attempt to investigate the allegation themselves; they have the clear responsibility to refer the concerns to the LCFS as soon as possible.

Line managers at all levels have a responsibility to ensure that an adequate system of internal control exists within their areas of responsibility and that controls operate effectively. The responsibility for the prevention and detection of fraud and corruption therefore primarily rests with managers but requires the co-operation of all employees. Failures by managers to apply effective internal financial controls and appropriate financial governance and verification could result in disciplinary action.

As part of that responsibility, line managers need to:

- inform staff of ABUHB's Standards of Business Conduct for Employees and the Counter Fraud, Bribery and Corruption Policy as part of their induction process, paying particular attention to the need for accurate completion of personal records and forms.
- ensure that all employees for whom they are accountable are made aware of the requirements of the policy.
- assess the types of risk involved in the operations for which they are responsible.
- ensure that adequate control measures are put in place to minimise the risks. This may include clear roles and responsibilities, supervisory checks, staff rotation (particularly in key posts), separation of duties wherever possible so that control of a key function is not invested in one individual, and regular reviews, reconciliations and test checks to ensure that control measures continue to operate effectively.
- ensure that any use of computers by employees is linked to the performance of their duties within the organisation.

- be aware of ABUHB's Counter Fraud, Bribery and Corruption Policy and the rules and guidance covering the control of specific items of expenditure and receipts.
- identify financially sensitive posts.
- ensure that controls are being complied with.

Employees

ABUHB's Standing Orders, Standing Financial Instructions, policies and procedures place an obligation on all employees and Independent Members of the Board to act in accordance with best practice.

Employees are expected to act in accordance with the standards laid down by their professional bodies, where applicable, and have a personal responsibility to ensure that they are familiar with them.

Employees also have a duty to protect the assets of the organisation including information, goodwill and property.

In addition, all employees have a responsibility to comply with all applicable laws and regulations relating to ethical business behaviour, procurement, personal expenses, conflicts of interest, confidentiality and the acceptance of gifts and hospitality.

All employees have a duty to ensure that public funds are safeguarded, whether or not they are involved with cash or payment systems, receipts or dealing with contractors or suppliers. If an employee suspects that there has been fraud, bribery or corruption, or has seen any suspicious acts or events, they must report the matter to the nominated LCFS.

LCFS

The Directions to NHS Bodies (Wales) on Counter Fraud Measures 2005 require the NHS organisation to appoint and nominate an LCFS. The LCFS's primary role is to

ensure that all cases of actual or suspected fraud, bribery and corruption are notified to the Director of Finance and investigated accordingly, and to provide a service that complies with all aspects the Government Functional Standard GovS 013 - Counter Fraud.

The LCFS will regularly report to the Director of Finance on the progress of investigations.

The LCFS will:

- ensure that the Director of Finance is informed about all referrals/cases areas of work that require escalation
- be responsible for the day-to-day implementation of the components/requirements of the of Government Functional Standard GovS 013 Counter Fraud
- investigate all cases of fraud.
- in consultation with the Director of Finance, report any case to the police or NHSCFA as agreed and in accordance with the NHS Counter Fraud Manual
- report any case and the outcome of the investigation through NHSCFA's national investigation management system (CLUE)
- ensure that other relevant parties are informed where necessary, e.g. WOD.
- ensure that any system weaknesses identified as part of an investigation are followed up with management and if appropriate, reported to Internal Audit
- not have responsibility for or be in any way engaged in the management of security for any NHS body

Internal and external audit

Any incident or suspicion of fraud that is brought to the attention of internal or external audit will be passed immediately to the nominated LCFS. The outcome of the investigation may necessitate further work by internal or external audit to review systems or processes. Internal Audit will liaise with the LCFS in accordance with the agreed liaison protocol.

Workforce and OD (WOD)

WOD will liaise closely with managers and the LCFS from the outset if an employee is suspected of being involved in fraud and/or bribery and/or corruption, in accordance with the agreed liaison protocol. WOD staff are responsible for ensuring the appropriate use of ABUHB's disciplinary procedure. WOD will advise those involved in the investigation on matters of employment law and other employment procedural matters, such as disciplinary and complaints procedures, as requested. Close liaison between the LCFS and WOD will be essential to ensure that any parallel sanctions (i.e. criminal, civil and disciplinary sanctions) are applied effectively and in a co-ordinated manner, and to ensure the welfare of any employees involved in an investigation.

NHSCFA & NHS Counter Fraud Service (Wales)

The NHSCFA has responsibility for national policy and operational matters relating to the prevention, detection and investigation of fraud, bribery and corruption in the NHS. NHSCFA has national investigation service teams sited in three geographical regions that investigate NHS fraud in England. The regional team that covers Wales is the Counter Fraud Service (Wales). It is funded directly by Welsh Government and is operationally independent of the NHSCFA, LCFS teams, and NHS Wales organisations.

They are responsible for:

- Investigating high value and cases that may be protracted
- dealing with all bribery and corruption cases.
- Investigating multi-organisation, cross border investigations
- Liaising with other NHSCFA regional teams
- Acting as Single Point of Contact for external partners such as Crown Prosecution Service, HMRC, Police National Computer.
- Hosting regular fraud forums to act as training for LCFS teams.
- Financial investigation and Proceeds of Crime Act asset seizure and financial recovery.

9. Counter Fraud Response Plan

This section outlines the action to be taken if fraud, bribery or corruption is discovered or suspected.

Reporting Fraud, Bribery & Corruption

If an employee has any of the concerns mentioned in this document, they should inform the nominated LCFS or the Director of Finance, Procurement & Value immediately. This can be done via the [ABUHB online reporting form](#). This method will ensure the speediest response to the concerns raised. The team can also be contacted directly via telephone and email. Contact information is provided at the [Fraud Pages](#) on the AB Pulse site. (If the Director of Finance or LCFS are implicated in a fraud referral then the matter should be reported to the Chair or Chief Executive, who will report the circumstances to Counter Fraud Service Wales for investigation).

Employees can also call the NHS Fraud and Corruption Reporting Line on freephone 0800 028 40 60. This provides an easily accessible route for the reporting of genuine suspicions of fraud, bribery or corruption, within or affecting the NHS. It allows NHS staff who are unsure of internal reporting procedures to report their concerns in the strictest confidence. All calls are dealt with by experienced trained staff and any caller who wishes to remain anonymous may do so. The [NHSCFA online reporting tool](#) is a further medium to report concerns.

ABUHB wants all employees to feel confident that they can expose any wrongdoing without any risk to themselves. In accordance with the provisions of the Public Interest Disclosure Act 1998, ABUHB has produced a raising concerns policy. This procedure is intended to complement the Counter Fraud Bribery and Corruption Policy and the Standards of Business Conduct for Employees and ensures there is full provision for staff to raise any concerns with others, without risk or prejudice to themselves and without fear of reprisal, if they do not feel able to raise them with their line manager/management chain.

Upon report of a concern the LCFS will make sufficient enquiries to establish whether or not there is any foundation to the suspicion that has been raised and make a decision on whether the matter needs to be formally investigated. In the event allegations are found to be malicious, they will also be considered for further investigation to establish their source.

Police involvement

In accordance with the NHS CounterFraud Manual, the Director of Finance, in liaison with the LCFS, will decide whether or not a case should be referred to the police. Any referral to the police will not prohibit any disciplinary action being taken.

The procedure for reporting fraud is outlined in the flowchart 'Chart 1' which is included with this policy as Appendix 1.

Managing the Investigation

The LCFS will investigate an allegation in accordance with procedures documented in the NHS Counter Fraud Manual issued by the NHSCFA.

ABUHB will follow its disciplinary procedure if there is evidence that an employee has committed an act of fraud, bribery or corruption.

The procedure for managing the investigation is outlined in the flowchart 'Chart 2' which is included with this policy as Appendix 2.

Gathering Evidence

The LCFS will take control of any physical evidence, and record this in accordance with the procedures outlined in the NHS Counter Fraud Manual.

Interviews under caution or to gather evidence will only be carried out by the LCFS or the investigating police officer and will be in accordance with the Police and Criminal Evidence Act 1984 (PACE). The LCFS will take written statements where necessary.

Where interviews are carried out under caution the employee has the right to be accompanied by a legal representative as defined under Code C - Section 6.12 Police and Criminal Evidence Act 1984.

The application of the Counter Fraud Bribery and Corruption Policy will at all times be considered in tandem with all other appropriate policies, e.g. Disciplinary Procedures, Standing Orders, Standing Financial Instructions (SFIs) and Irregularities.

The procedure for gathering evidence is outlined in the flowchart 'Chart 3' which is included with this policy as Appendix 3.

The interview procedure is outlined in the flowchart 'Chart 4' which is included with this policy as Appendix 4.

Recovery of losses incurred to fraud, bribery and corruption

The seeking of financial redress or recovery of losses should always be considered in cases of fraud, bribery or corruption that are investigated by either the LCFS or NHS Counter Fraud Service (Wales). As a general rule, recovery of the loss caused by the perpetrator should always be sought. The decisions must be taken in the light of the particular circumstances of each case.

Redress allows resources that are lost to fraud, bribery and corruption to be returned to the NHS for use as intended, for provision of high-quality patient care and services.

Reporting the results of the investigation

The investigation process requires the LCFS to review the systems in operation to determine whether there are any inherent weaknesses. Any such weaknesses identified should be reported to the relevant Division immediately in order that remedy is considered and implemented.

If fraud, bribery or corruption is found to have occurred, the LCFS should prepare a report for the Director of Finance at the conclusion of a case. In addition, the LCFS will

report regularly to Audit Risk and Assurance Committee meeting, providing details of ongoing investigations and the results of investigations concluded.

The following details to be provided are a guide:

- Details of the allegation
- Details of the investigation
- Details of identified losses
- System weaknesses identified
- Recommendations made

Sanctions and Redress

Section 6 of the NHS Counter Fraud Manual provides in-depth details of how sanctions can be applied where fraud and corruption is proven and how redress can be sought. To summarise, local action can be taken to recover money by using the administrative procedures of the organisation or civil law.

In cases of serious fraud, bribery and corruption, it is recommended that parallel sanctions are applied. For example: disciplinary action relating to the status of the employee in the NHS; use of civil law to recover lost funds; and use of criminal law to apply an appropriate criminal penalty upon the individual(s) and/or a possible referral of information and evidence to external bodies – for example, professional bodies – if appropriate.

The NHS Counter Fraud Service (Wales) can also apply to the courts to make a restraining order or confiscation order under the Proceeds of Crime Act 2002 (POCA). This means that a person's money is taken away from them if it is believed that the person benefited from the crime. It could also include restraining assets during the course of the investigation.

Actions which may be taken when considering seeking redress include:

- no further action
- criminal investigation

- civil recovery
- disciplinary action
- confiscation order under POCA
- recovery sought from ongoing salary payments

In some cases (taking into consideration all the facts of a case), it may be that ABUHB under guidance from the LCFS and with the approval of the Director of Finance, decides that no further recovery action is taken.

Criminal investigations are primarily used for dealing with any criminal activity. The main purpose is to determine if activity was undertaken with criminal intent. Following such an investigation, it may be necessary to bring this activity to the attention of the criminal courts (Magistrates' Court and Crown Court). Depending on the extent of the loss and the proceedings in the case, it may be suitable for the recovery of losses to be considered under POCA.

The civil recovery route is also available to ABUHB if this is cost-effective and desirable for deterrence purposes. This could involve a number of options such as applying through the Small Claims Court and/or recovery through Debt Collection Agencies. Each case needs to be discussed with the Director of Finance to determine the most appropriate action.

The appropriate senior manager, in conjunction with WOD, will be responsible for initiating any necessary disciplinary action. Arrangements may be made to recover losses via payroll if the subject is still employed by the organisation. In all cases, current legislation must be complied with.

The recovery of losses should be commenced as soon as practicable after the loss has been identified. Given the various options open to ABUHB, it may be necessary for relevant departments to liaise concerning the most appropriate course of action to be taken to facilitate the recovery.

In order to provide assurance that policies have been adhered to, the Director of Finance will maintain a record, highlighting when recovery action was required and issued, and when the action taken. This will be reviewed and updated on a regular basis.

10. Training

Fraud training is provided as eLearning on the ESR system. All staff are mandated to undertake this training every three years. The LCFS is committed to providing bespoke fraud training packages to all Divisions across the organisation upon request.

11. Communication with Media

11.1. The Head of Communications and the Director of Finance 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.

11.2. Consideration should be given to contacting 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.

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

11.4. Any request to the LCFS for a media interview will be directed to the 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 Head of Communications as a matter of courtesy in case there is further interest from other media groups.

12. Further Information

For further information please visit

<https://cfa.nhs.uk>

[Fraud - Home](#) ABUHB

13. References

Directions to NHS Bodies on Counter Fraud Measures (National Assembly Wales)

NHS Counter Fraud Manual

NHS Counter Fraud Strategy

Public Interest Disclosure Act 1998

The Fraud Act 2006

Bribery Act 2010

Disciplinary Policy

Standing Financial Instructions

Standing Orders

Standards of Business Conduct for Employees

Raising Concerns Policy

Government Functional Standard GovS 013 Counter Fraud

14. Appendices

Included with this policy are the following appendices:

Appendix 1 – Chart 1 Reporting Fraud

Appendix 2 – Chart 2: Managing the Investigation

Appendix 3 – Chart 3: Gathering Evidence

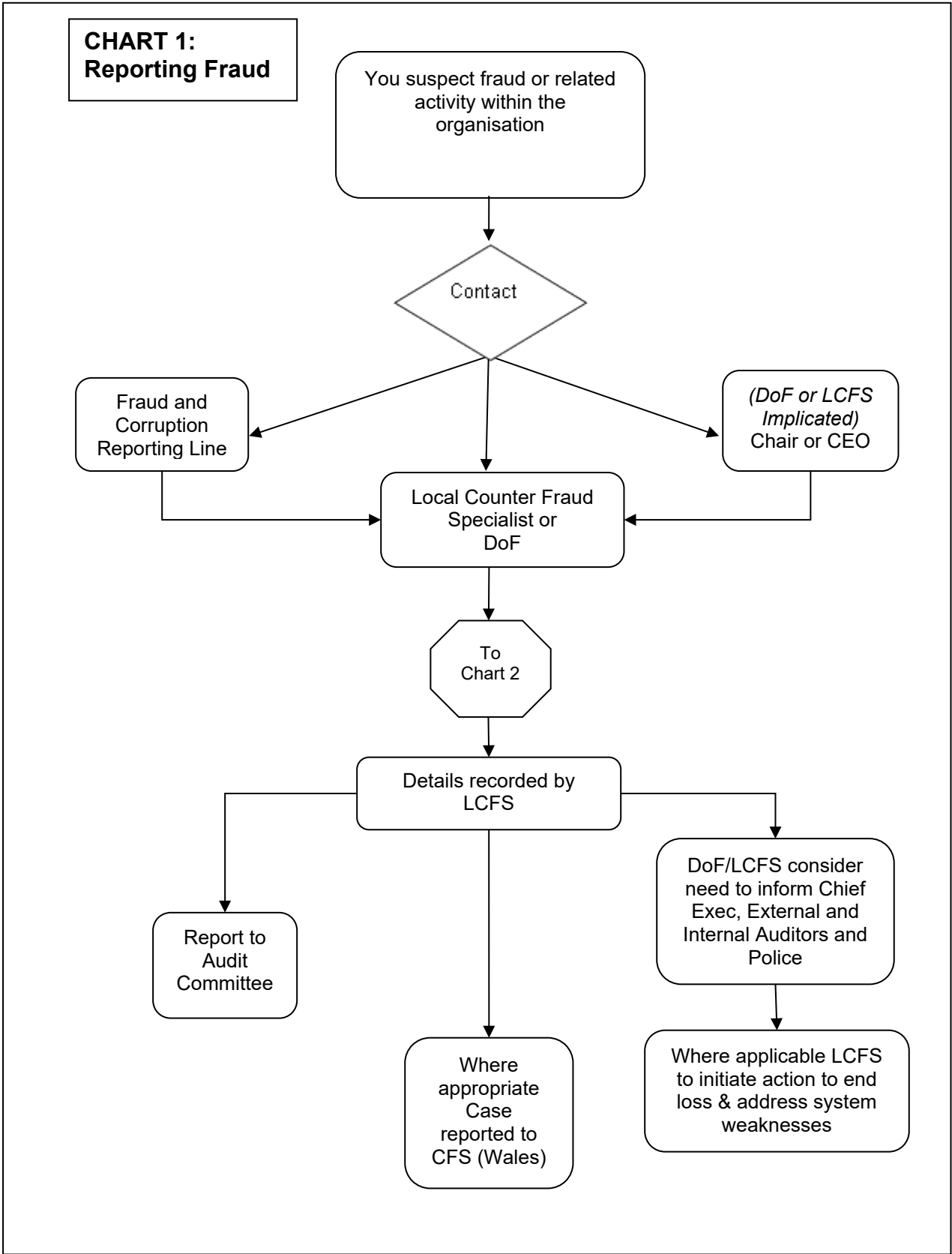
Appendix 4 – Chart 4: Interview Procedure

Appendix 5 – Counter Fraud and Workforce & OD Protocol

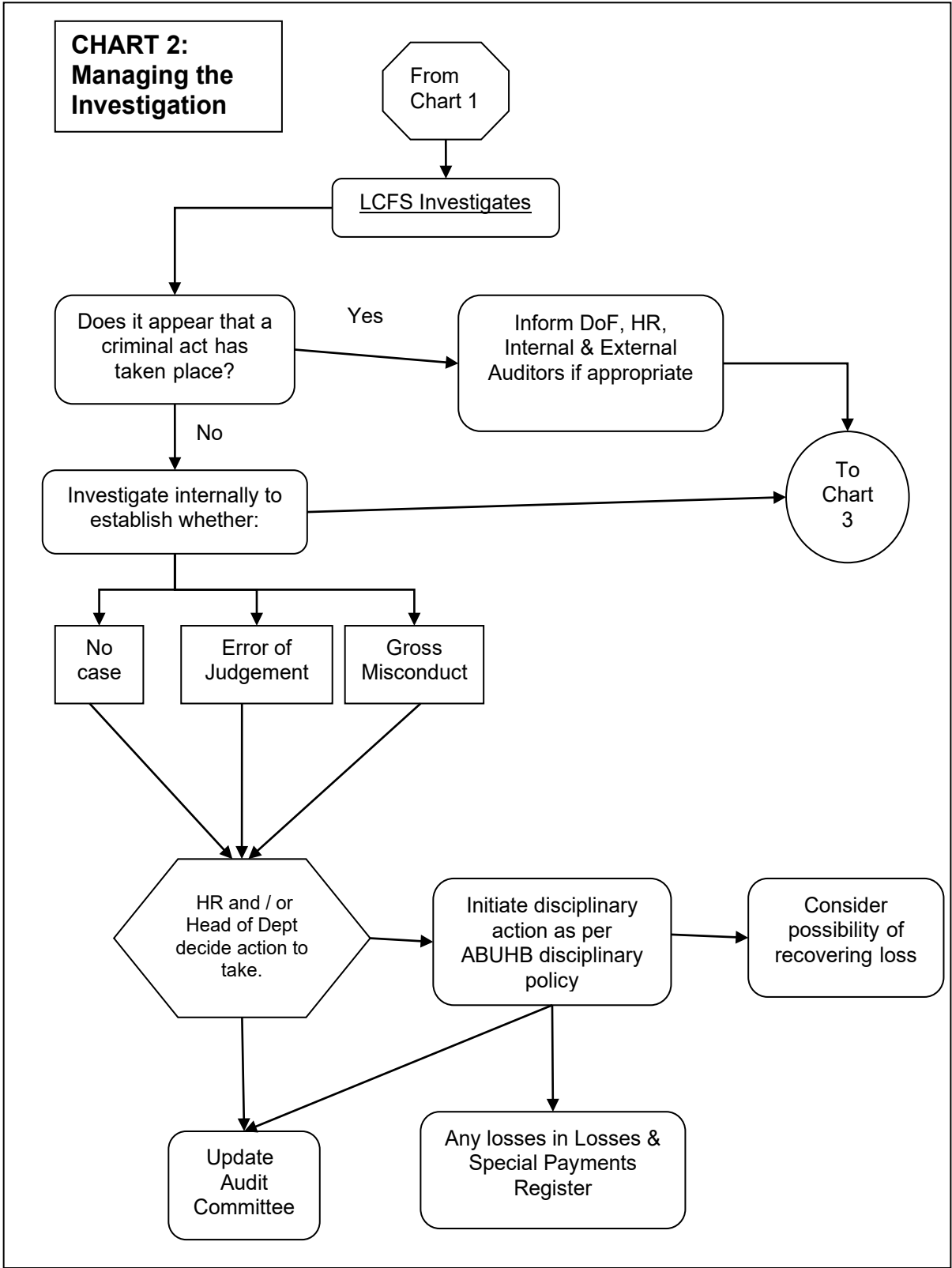
Appendix 6 – Counter Fraud and Internal Audit Protocol

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

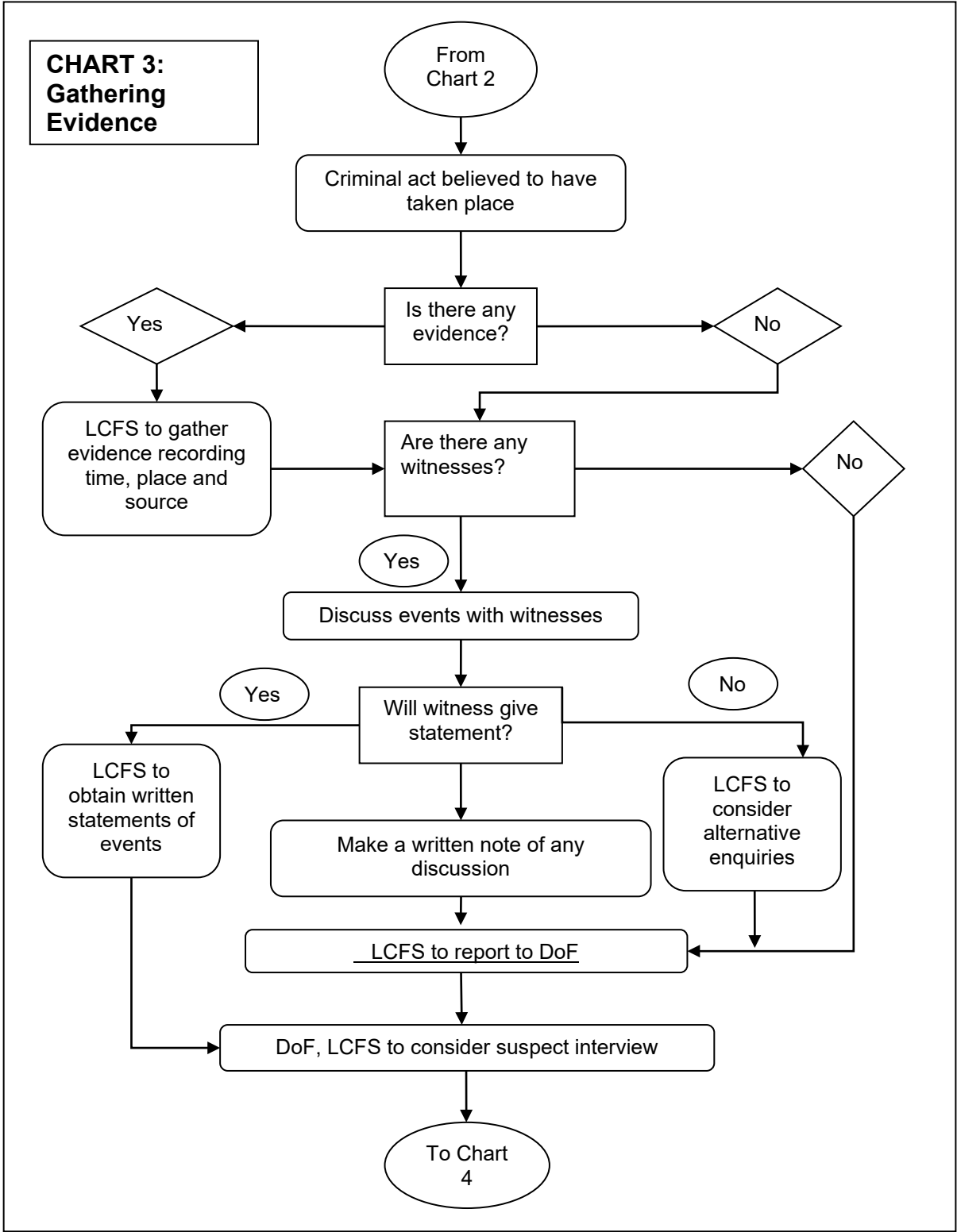
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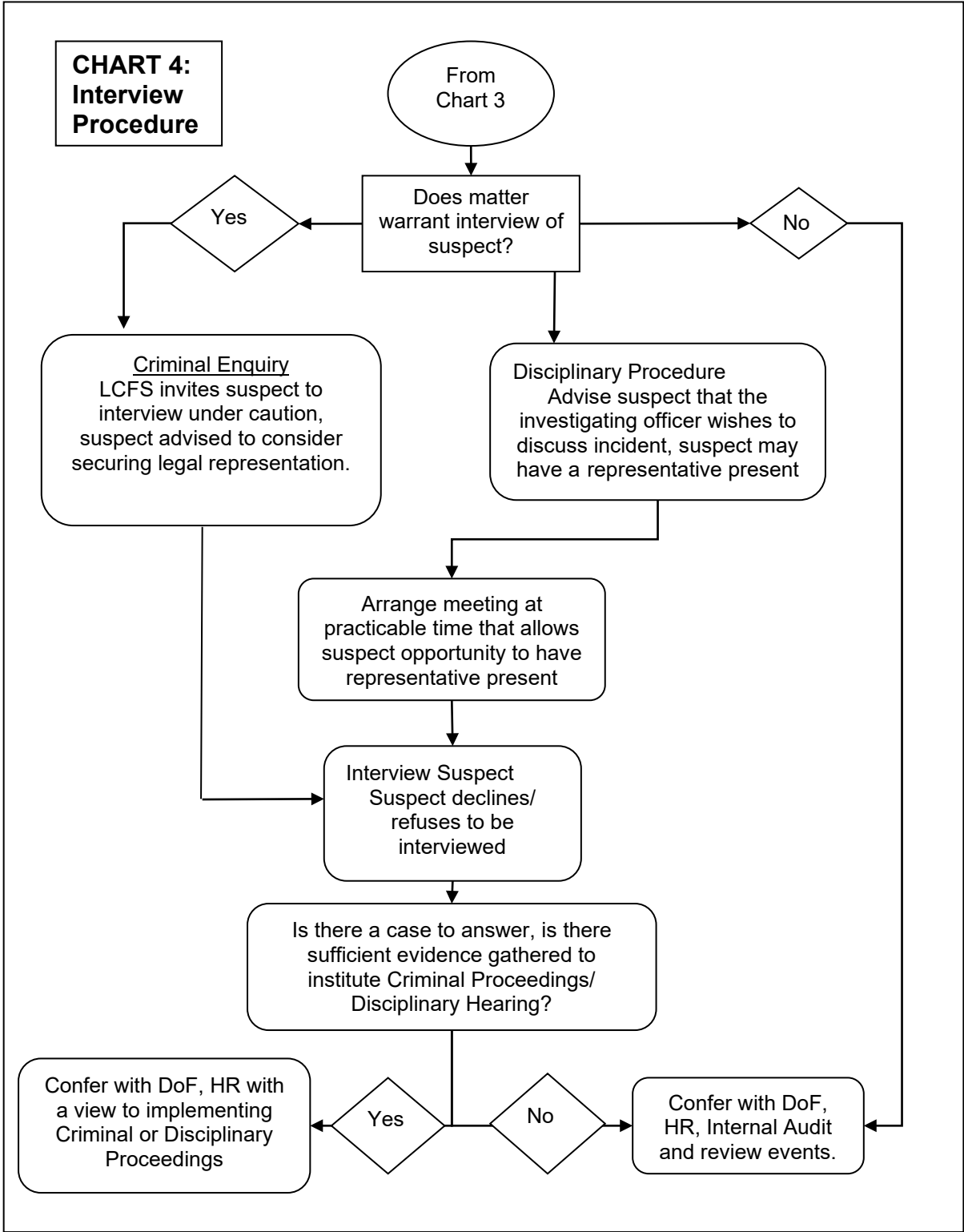
Appendix 2



Appendix 3



Appendix 4



Appendix 5

Counter Fraud and Workforce & OD Joint Working Protocol

1. Introduction

1.1

This document has been established to enable effective interaction between the Local Counter Fraud Specialist (LCFS) and Workforce and OD (WOD).

1.2

This protocol is a framework for interaction between WOD and Counter Fraud (CF) teams when a potential fraud is highlighted involving, or that may impact upon, a staff member of the organisation. Applying the protocol aims to ensure that the most appropriate action is taken by all parties involved at the earliest opportunity. It is imperative that informed decisions are made to direct how the investigation will proceed. i.e. criminal, employment, or professional or a range of these. CF and WOD representatives will work closely to determine the proposed actions of all parties, to ensure that lines of enquiry and responsibilities are clearly defined. In addition, it is critical that relevant information is shared between parties, where lawful, and where parallel investigations are undertaken, that they remain independent of each other. Senior Finance and Workforce advice should be taken whenever there is any conflict between the two roles regarding a course of action to be taken.

1.3

Being subjected to a Disciplinary or LCFS process will inevitably be a difficult time for the employee, and any associated witnesses. The Health Board remains committed to discharging its responsibilities in these processes effectively and efficiently, ensuring that proportionate and reasonable action is taken based on available information. Staff will be advised of the support available to them throughout the process, and their right of representation at any formal investigation meetings.

1.4

This protocol is not a definitive procedural document as individual investigations may highlight specific issues requiring a bespoke approach. This does not prejudice the

need to conduct potential fraud investigations in accordance with criminal and civil law and all relevant aspects of employment law.

1.5

Where possible investigations should be run simultaneously (termed parallel investigations). In order that they are effective close liaison must exist between the LCFS and Workforce as findings from one investigation might be relevant to another. A case conference will be undertaken involving LCFS and WOD, and Division, to identify necessary actions / responsibilities and agree an investigation strategy. It may be necessary if circumstances dictate, that the criminal investigation will determine the actions and timing of other related investigations. It may be requested that any internal assessment or investigation related to employment procedures is placed on hold or delayed whilst the Counter Fraud enquiry is progressed. It may also be requested by the LCFS that notification to the subject that an allegation has been received is delayed. This will normally be due to reason of evidence preservation and to the higher burden of proof placed upon criminal investigations and the resultant due process legislation that covers the gathering of evidence. This will be a joint decision. The Head of Counter Fraud will record all decisions made in relation to these matters and if delays are requested, provide justification.

1.6

This protocol takes into account the NHS policy document Applying Appropriate Sanctions Consistently, and should be read in conjunction with this document. Applying Appropriate Sanctions Consistently provides specialist and legal advice on how to conduct investigations to ensure the full range of sanctions is considered and can be applied in all fraud or corruption investigations. A link to this document is provided below.

2. General Principles

2.1

Outlined below is a list of general principles that should govern investigations and the sharing of information between the LCFS and Workforce. This should be

supported by regular meetings between Counter Fraud and Workforce, that commences with a case conference.

2.2

Formal criminal investigations into fraud and employment investigations focussing on employment / disciplinary matters must remain separate and independent. LCFS is not permitted to be involved in employment procedure investigations and is not permitted to direct them. However, information collected during investigations, where lawful and appropriate, should be shared. This aims to prevent duplication of effort, enhance decision making and provide assurance that the investigations are being conducted effectively and efficiently.

2.3

Information sharing within an organisation remains subject to the General Data Protection Regulations and the Data Protection Act 2018.

2.4

Any witness must have given their written consent for their statement given as part of the criminal investigation to be used for civil or employment procedure purposes. Where members of staff are requested to provide a formal witness statement during the course of an investigation, they will be provided support from Counter Fraud team throughout. Additional support is available from Trade Unions and Wellbeing services, signposting to relevant support services will be shared.

2.5

Tapes or transcripts of interviews under caution should only be used in the furtherance of a criminal investigation and not for employment procedure purposes unless an overriding issue concerning public health or safety determines otherwise, or the interviewee consents. Likewise, information derived from third parties under Part 3 Chapter 1 of the Data Protection Act 2018 in pursuance of a criminal investigation where there is no longer an intention to pursue a criminal sanction should only be shared if, when that information is being requested under Part 3 Chapter 1 it is made clear that it may be used for internal disciplinary purposes.

2.6

At the conclusion of a formal fraud investigation the Head of Counter Fraud will ensure that the Division and Workforce are provided with an investigation closure report

detailing, the outcome of the investigation; the conclusion drawn; and any recommendations or learning requirement that has been identified. This closure report should not be used as part of the employment investigation process. The closure report should not be retained on an employee's personal file following the conclusion of a counter fraud process. Divisions should ensure that closure reports are managed and retained in accordance with the Health Board Record Management Policy. Should the appointed investigation officer require input from the Counter Fraud investigation then the LCFS will provide a disciplinary statement. The Counter Fraud team will also be responsible for highlighting any identified fraud risks and bringing these to the attention of relevant stakeholders. This will be carried out in compliance with the organisations Risk Management Policy. The Division is responsible for the onward management of any further local action or learning.

2.7

The decision to suspend or exclude an employee will rest with the appropriate senior manager after taking Workforce advice. This action will be taken in accordance with the Disciplinary or Upholding Professional Standards in Wales Policy where appropriate. Where the individual is subject to a LCFS investigation, the Head of Counter Fraud will be informed of the managers decision to suspend.

3. Liaison Responsibilities

3.1

LCFS will arrange a case conference when a referral/allegation of fraud is submitted, to include appropriate stakeholders including Workforce. It is imperative that all parties are informed of the referral/allegation at the earliest opportunity in order to ensure that an effective investigation and employee welfare strategy can be agreed upon.

3.2

LCFS and Workforce will meet at regularly defined intervals to discuss all ongoing cases that involve both parties. If necessary ad hoc meetings will be undertaken as the need arises.

3.3

Meetings between LCFS and Workforce will aim to include a senior member of Directorate unless this is not appropriate. If circumstances require escalation, inclusion

of the DoF and Divisional Directors into these meetings will be considered and acted upon.

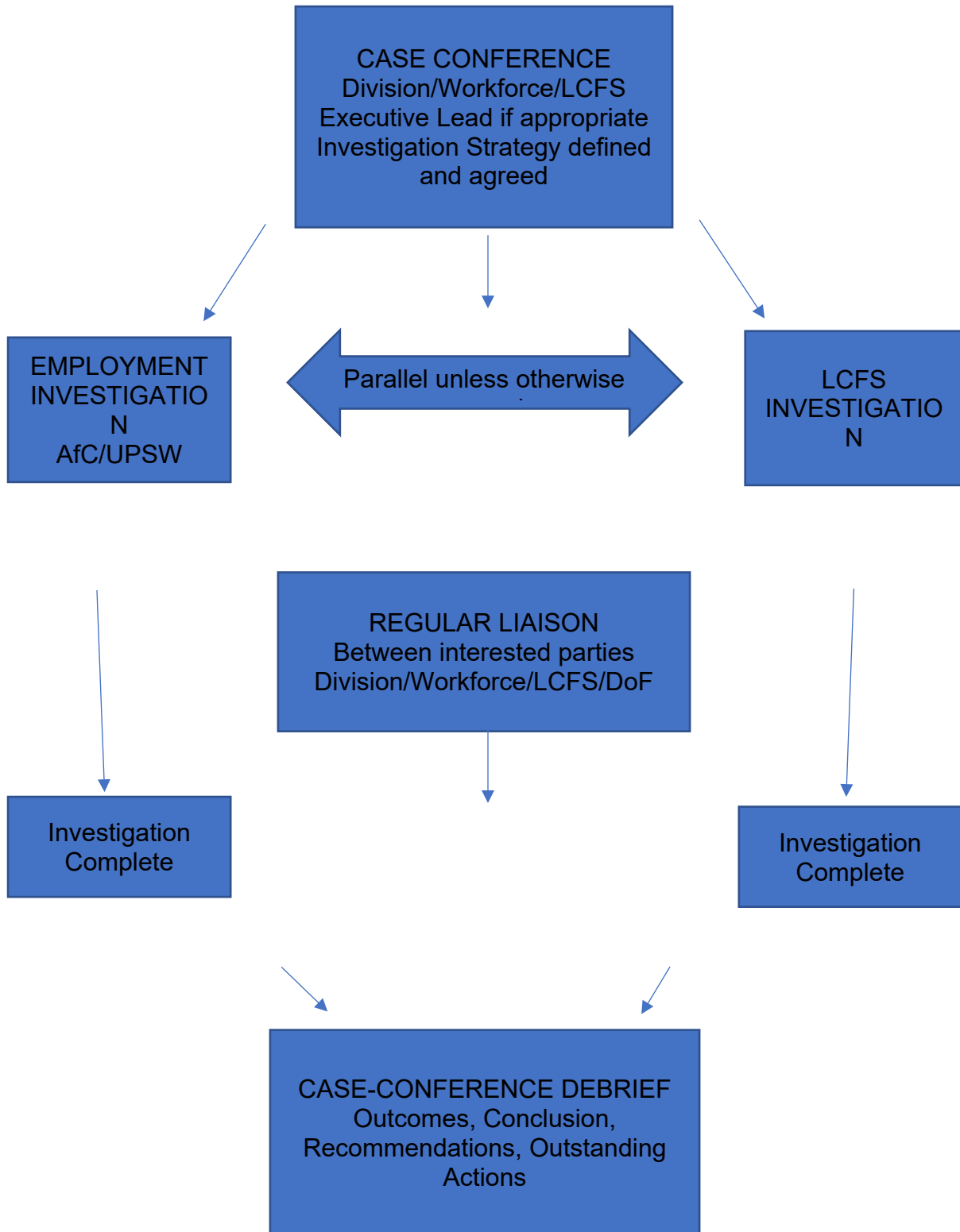
3.4

At the conclusion of an investigation LCFS and Workforce will meet to discuss the outcomes, conclusion, recommendations and any identified further actions, resulting from all investigations.

3.5

If necessary LCFS will liaise with external partners (Police, Counter Fraud Service Wales, NHS Counter Fraud Authority). Should an investigation be referred on to one of these services LCFS will inform Workforce and identify a point of contact in order that effective liaison can be maintained.

4. The Liaison Process



5. Associated Documents

- Raising Concerns (Whistleblowing) Policy
- Applying Appropriate Sanctions Consistently
- Speaking up Safely Framework
- Counter Fraud Bribery and Corruption Policy
- Disciplinary Policy and Procedure
- Upholding Professional Standards in Wales policy
- Other Health Board policies

Policies Home Site – Home

Appendix 6

Counter Fraud and Internal Audit Joint Working Protocol

1 Introduction

1.1 This document has been established to enable, and evidence, effective interaction, co-ordination and sharing of information between the Local Counter Fraud Specialist (LCFS) and Internal Audit (NWSSP Audit & Assurance Services). Once signed it remains in force unless any changes are agreed by both signatories.

1.2 The protocol is a framework for general interaction between the LCFS and Internal Audit to aid the prevention, deterrence and detection of any potential fraud and economic crime within the organisation. To reduce the risk of fraud and economic crime within the organisation there needs to be close and supportive liaison between the LCFS and Internal Audit functions. This includes the sharing of information to reduce the risk of the organisation falling victim to fraudulent practices from perceived weaknesses in internal system controls. A strong liaison between these two functions is also required to avoid the potential for an investigation to be compromised.

1.3 In any areas of conflict between the two functions, the Director of Finance for the relevant HB/Trust and the Director of Audit & Assurance should be consulted.

2 Background

2.1 Under the then Welsh Assembly Government (Revised) Directions to National Health Service bodies on Counter Fraud Measures 2005, there is an outline of liaison responsibilities of the LCFS and auditor roles.

2.2 The *NHS Counter Fraud Manual* (3.4.3) recognises the need for a close liaison between Internal Audit and the LCFS so that these functions can work together to reduce the opportunities for fraud and economic crime to enter the organisation's systems. Whilst the two roles are complementary they should also demonstrate clear distinction. Internal Auditors will routinely test systems and processes whilst the LCFS will investigate where there is suspicion that the systems have been breached. The LCFS will also report on how systems can be strengthened to limit the risk of fraud and economic crime and this prevention work complements rather than duplicates the work of the Internal Auditor.

2.3 The *Public Sector Internal Audit Standards (PSIAS)* identifies the role of Internal Audit in relation to fraud.

2.4 As LCFS and Internal Audit are provided by separate parts of NHS Wales there is a strong need to define the relationship between Internal Audit and the NHS Counter Fraud Service (NHS CFS) and the need for clearly defined responsibilities for the LCFS.

3 Internal Audit liaison responsibilities

3.1 Internal Audit's role in relation to fraud is set out in the PSIAS and is included in the Internal Audit Charter (see Section 11) that is approved annually by the Audit Committee. Specific references to our role can be found in the PSIAS at sections 1210, 1220, 2060, 2120 and 2210.

3.2 Internal Audit will formally meet with the LCFS, at least biannually, to discuss liaison requirements plus any potential duplication within the LCFS work plan and the Internal Audit programme.

3.3 The LCFS is to be included in any final Internal Audit report circulation list whenever systems weaknesses have been identified that may provide the opportunity for fraud or corruption to occur or remain undetected.

3.4 If a concern about a risk of financial abuse is identified during an audit, the LCFS will be notified immediately so that appropriate procedures can be followed. The LCFS will also be notified if a member of staff approaches Internal Audit with any knowledge or suspicion of fraud occurring.

3.5 Internal Audit will be notified by LCFS where any of their concluding reports identify system weaknesses. When practical, and applicable, a review should be undertaken by Internal Audit so that all system weaknesses, risks and recommendations can be outlined to the HB/Trust Director of Finance. This may need to be undertaken as a system audit to obtain a complete overview (see 3.6 and 4.5 below).

3.6 If the recommendations made by the LCFS cannot be reviewed as stated in 3.5, Internal Audit will notify the LCFS so that another review action can be considered.

3.7 If the Internal Auditors are aware of an ongoing investigation, they will notify the LCFS if they need to visit that area as a result of new information being received.

3.8 To assist an investigation, Internal Audit will fulfil any LCFS request for information regarding system weaknesses/recommendations made in an area being investigated by the LCFS.

4 LCFS liaison responsibilities

4.1 Formally meet with a designated Internal Auditor at least bi-annually to discuss potential duplication of work within the LCFS workplan and the Internal Audit programme. Summary minutes/outcomes of these meetings should be maintained.

4.2 Notify Internal Audit of any fraud bulletins that may affect the audit work programme.

4.3 The LCFS will review the possibility of a proactive audit/risk assessment into any area identified by Internal Audit as being at risk of fraudulent/financial abuse. Such work will be discussed with the Director of Finance and, if agreed, included in the annual workplan.

4.4 The LCFS will notify Internal Audit of any proactive reviews being undertaken to minimise the possible duplication of data collection (this will include NHS CFS national proactive exercises).

4.5 The LCFS will notify the Internal Auditors of any system weaknesses identified as part of a fraud investigation, risk assessment or proactive exercise. This will allow them to consider appropriate follow-up action and provide an opinion on best practice internal control.

4.6 Where appropriate, the LCFS will notify Internal Audit of any investigations that are ongoing at the organisation so that any potential conflicts can be negated. Information provided will be restricted to clarification of the area involved and an overview of the concern. For disclosure purposes, confidentiality should remain a priority.

4.7 The LCFS will notify Internal Audit of any fraud alert notification received so that appropriate local testing can be undertaken and controls checked for robustness. Further work will be required by the LCFS if the auditors identify that the systems may already have been breached.

4.8 Acknowledge receipt of any Internal Audit referral and arrange to meet with an appropriate representative to discuss. The LCFS will then undertake an initial and timely review to establish the validity of the referral.

5 Associated risks if effective interaction is not in place

5.1 Duplication of work may occur between the LCFS and Internal Audit functions if close interaction is not maintained.

5.2 Prevention controls will be weakened if the two functions are not communicating effectively.

5.3 There is an inherent risk that an investigation could be compromised if these two functions are not aware of the work being undertaken or the work that is proposed.

DYDDIAD Y CYFARFOD: DATE OF MEETING:	18 February 2025
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Update on Single Quotation and Tender Actions –19 th October 2024 to 24 th January 2025
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Robert Holcombe, Director of Finance, Procurement and Value Based HealthCare
SWYDDOG ADRODD: REPORTING OFFICER:	Alex Curley – Head of Procurement

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA

SBAR REPORT

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

Appendix A provides specific detail regarding the Single Quotations / Actions that have been submitted and approved for the period 19th October 2024 to 24th January 2025.

Cefndir / Background

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

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

- Review of Single Quotation and Tender Requests.

Asesiad / Assessment

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

There have been 8 requests submitted which has been approved during the period with an annual value of £287,005.74 Ex VAT. The overall value of these 8 awards comes to £461,287.08 Ex VAT.

Of the 8 approved requests there were 3 classified as goods only, 3 classified as maintenance, 1 of services and a further 1 classified as both goods & services.

Argymhelliad / Recommendation

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

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



Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Is EIA Required and included with this paper 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.



Appendix A - Summary of Single Tender/Quotation Actions

Date of Request	Type of Request	Reference No	Description	Anticipated Annual Value (ex VAT)	Total Contract Value (Ex VAT)	Supplier	Type	Reason for request	Advice from Procurement	Reasoning if procurement exercise delayed	Approved / Rejected	CEO & DoF Approval Date	Chair or WG Approval Date
05/11/24	Single Quotation	ABU-SQA-57689	Maintenance - Safemate Eco Cabinets	£1,869.60	£9,348.00	Techniplast	Maintenance	The cabinets are manufactured by an Italian supplier, Bioair and only limited suppliers have access to the software to be able to change the settings and modify airflow.	Supplier can provide password access to be able to perform the necessary maintenance on the system	N/A	Approved	25/11/24	N/A
09/10/24	Single Tender	ABU-STA-57473	KONE Lift Maintenance (GUH, Tredegar and Ty Gwent) for 3 Years	£36,750.00	£110,250.00	KONE Plc	Maintenance	KONE are the lift installers/manufacturers at GUH and Tredegar and must maintain their own parts to comply with warranty. No direct award options available with this supplier.	There is a requirement for KONE to maintain their own equipment to ensure that there are no challenges further down the line should a third party maintain the equipment	N/A	Approved	27/11/24	N/A
25/10/24	Single Tender	ABU-STA-145530	Maintenance Microscopes and colposcopes	£30,163.20	£90,489.60	Carl Zeiss	Maintenance	No competition is available, and equipment does not sit under framework currently. Average age of the equipment is 3 /4 years, so having considered age profile of the devices to be covered and the costs associated against them maintenance renewal is proposed for 3 years – future oem maintenance contract with this supplier will run alongside so they can be renewed together allowing future contract efficiency and value for money	The manufacturer is the only supplier that can maintain the equipment on this contract	N/A	Approved	04/11/24	N/A

Date of Request	Type of Request	Reference No	Description	Anticipated Annual Value (ex VAT)	Total Contract Value (Ex VAT)	Supplier	Type	Reason for request	Advice from Procurement	Reasoning if procurement exercise delayed	Approved / Rejected	CEO & DoF Approval Date	Chair or WG Approval Date
11/11/24	Single Tender	ABU-STA-145643	Digital Pathology Scanner	£79,143.68	£112,120.22	Leica Biosystems	Goods	Rental of an automated, high-capacity digital Pathology scanner - Welsh Government Funded	The STA is an appropriate course of action to ensure compatibility with the new LIMS system and to continue the Health Boards project support for the above mentioned AI Projects.	N/A	Approved	21/11/24	N/A
20/11/24	Single Tender	ABU-STA-57793	RGH Pharmacy Furniture	£65,595.46	£65,595.46	SKK Interiors	Goods	ABUHB has a requirement for the fabrication and installation of new clinical storage and workbenches for an ABUHB Pharmacy Department at the Royal Gwent Hospital, Newport. This design package has been carried out by T3 Design and they have put forward design packages for the successful supplier to follow and deliver. The furniture needs to be delivered and installed by latest early March 2025 time.	Having tested the market and received no bids the STA is an appropriate course of action	N/A	Approved	27/11/24	N/A
10/12/24	Single Tender	ABU-STA-55474	International Nursing Accommodation	£12,740.00	£12,740.00	Campus Living Villages	Services	In 2022, All-Wales International Nurse recruitment campaign engaged with Facilities and Procurement to explore accommodation options across Wales. The outcome of the findings was limited and expensive accommodation available across Wales. A failed tendering exercise was undertaken in January 2024, the only bidder didn't qualify. NSV did not	Due to the urgent requirement for this accommodation, timescales remaining and previously failed tender exercise, along with market knowledge of a known shortage of suitable accommodation an SQA is agreed on this occasion.	N/A	Approved	30/12/24	N/A

Date of Request	Type of Request	Reference No	Description	Anticipated Annual Value (ex VAT)	Total Contract Value (Ex VAT)	Supplier	Type	Reason for request	Advice from Procurement	Reasoning if procurement exercise delayed	Approved / Rejected	CEO & DoF Approval Date	Chair or WG Approval Date
								submit a bid under the tendering exercise.	Procurement will work with the division in order to establish a Framework agreement that will allow for future call off requirements.				
13/12/24	Single Tender	ABU-STA-58052	Capital - Fluroscopy Replacement Parts for	£32,319.00	£32,319.00	Probo Medical Ltd	Goods	Capital Funded - PROBO Medical have the Maintenance Contract until 2027 to maintain the Axiom Artis Zee MRI Fluroscopy Machine - This was accidental damage during a list so is not covered by Maintenance Contract.	As the maintenance provider for this equipment and to ensure there are no issues with maintenance liability it is agreed that an STA is an appropriate course of action.	N/A	Approved	08/01/25	N/A
21/01/25	Single Tender	ABU-STA-58297	KONE - Lift Rope Replacements GUH	£28,424.80	£28,424.80	KONE Plc	Goods and Services	Replacement lift ropes for lift at GUH - Kone is the OEM and maintenance provider so they can only undertake this work. They are not on any valid frameworks either. Lift 5 and lift 6 at GUH (main central core public lifts to all wards and maternity) are two of the most heavily trafficked lifts in the hospital. The Zurich lift in sections and Kone maintenance provider) have indicated enhanced wear and tear on the ropes of these lifts such that it would be advisable to change the ropes within the next 2 months to avoid shutting down the lifts due to a safety concern. This Single Tender Action is for Kone to supply and	The STA is an appropriate approach to this agreement to ensure continuity of the maintenance support from KONE - The lifts were installed by KONE	N/A	Approved	23/01/25	N/A

Date of Request	Type of Request	Reference No	Description	Anticipated Annual Value (ex VAT)	Total Contract Value (Ex VAT)	Supplier	Type	Reason for request	Advice from Procurement	Reasoning if procurement exercise delayed	Approved / Rejected	CEO & DoF Approval Date	Chair or WG Approval Date
								fit new main suspension ropes to lift 5 and lift 6 at GUH. The price also includes provision of bespoke scaffolding and/or access towers and specialist lifting equipment required to facilitate safe access to the various work areas and lift equipment.					
			Total	£287,005.74	£461,287.08								

DYDDIAD Y CYFARFOD: DATE OF MEETING:	18 February 2025
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Committee Risk and Assurance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Corporate Risk and Assurance

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

This report presents the Audit, Risk and Assurance Committee (the Committee) with an assessment of the strategic risks related to the Board's strategic objectives and provides assurance that these risks are being effectively managed.

Cefndir / Background

The Strategic Risk Report, last presented to the Committee on 12 November 2024, comprised **eight** principal risks and **19** sub-risks.

Since the previous Committee meeting, the Board convened on 26 November 2024 and 22 January 2025, approving several changes to the Strategic Risk Register.

At its November 2024 meeting, the Board approved the separation of **SRR 004** into two distinct risks, as the combined structure had failed to adequately differentiate between the risks associated with Major Incident and Business Continuity preparedness.

While Major Incident readiness (SRR 004A) was deemed robust, Critical Incident preparedness (SRR 004B) remained underdeveloped due to inconsistent business continuity arrangements. This separation aimed to enhance risk assessment, transparency, and management effectiveness.

During its January 2025 meeting, the Board approved the risk reduction of **SRR 001A** following measurable improvements in recruitment, retention, and governance. These developments supported a reduction in the likelihood score from 4 (Likely) to 3 (Possible), while the impact score remained at 4 (Major) to reflect ongoing vulnerabilities in patient care and compliance. As a result, the overall risk score was adjusted to 12 (High).

Additionally, the Board approved a new strategic risk (**SRR 011**), recognising the growing challenges in meeting the Welsh Government’s decarbonisation targets. This risk was categorised as Extreme, with a score of 15, based on a likelihood of 5 (Almost Certain) and an impact of 3 (Moderate). Despite its classification as an Extreme risk, it remains within the Board’s threshold and appetite for risks attributed to service delivery.

The Board also reaffirmed its delegation of risk oversight responsibilities to various committees, ensuring that each strategic risk receives appropriate scrutiny and assurance. This approach aligns with the Board’s Risk Management Framework, enhancing governance and expertise in addressing key organisational risks.

Asesiad / Assessment

Strategic Risk Register

In accordance with best practices, all strategic risks undergo regular review to ensure that the control environment remains robust and adequate for managing identified risks. Where existing controls are deemed insufficient, additional mitigation measures are documented, and action taken to address these gaps. Similarly, assurances are continuously evaluated across the Three Lines Model to assess the effectiveness and reliability of existing controls.

If gaps in assurance are identified, the control environment is reassessed, and appropriate measures are put in place to strengthen risk management. Conversely, when gaps in assurance are found, it is essential to develop and implement effective assurance mechanisms to transition from reassurance to robust, evidence-based assurance. This ensures that risks are actively managed and mitigated with the appropriate oversight and verification processes in place.

A high-level summary of the **nine** principal strategic risks is presented in Table 1, with further details provided in **Appendix A** (Risk Dashboard and individual risk assessments for the 21 sub-risks).

It is important to note that **SRR 001H**, **SRR 003**, and **SRR 009** have been previously de-escalated to corporate or divisional risk levels and are therefore excluded from Table 1. Additionally, **SRR 001E**, **SRR 004A**, **SRR 007A**, and **SRR 008A** have a risk score of 8 (Moderate Risk) and are not included in the risk level columns of Table 1.

Only the number of ‘High’ and ‘Extreme’ risks are provided.

Table 1

Overarching Strategic Risk Description	Sub-Risks	Risk Level		Sub-Risk Theme	Delegated Committee
		High (9 – 12)	Extreme (15 – 25)		
SRR 001 - There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population.	A, B, C & D	3	1	People	People and Culture Committee
	*E & F	-	1	Service Delivery	Partnerships, Public Health & Planning Committee
	G	-	1	Financial Sustainability	Finance and Performance Committee
	I	-	1	Compliance and Safety	Finance and Performance Committee
SRR 002 - There is a risk that there will be significant failure of the Health Board's estate.	A & B	1	1	Compliance and Safety	Partnerships, Public Health & Planning Committee
SRR 004 - There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to a major incident, business continuity incident or critical incident.	*A & B	1	-	Compliance and Safety	Partnerships, Public Health & Planning Committee
SRR 005 - There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.	A	1	-	Service Delivery	Patient Quality, Safety & Outcomes Committee
SRR 006 - There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.	A, B & C	2	1	Service Delivery	Finance and Performance Committee
SRR 007 - There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	*A & B	1	-	Transformation & Partnership Working	Partnerships, Public Health & Planning Committee
SRR 008 - There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.	*A	-	-	Transformation & Partnership Working	Patient Quality, Safety & Outcomes Committee
SRR 010 - The Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the	A	-	1	Compliance and Safety	Patient Quality, Safety & Outcomes Committee

Health and Safety at Work Act 1974					
SRR 011 - The Health Board is at risk of failing to meet the Welsh Government's Public Sector emissions reduction targets of 16% by 2025 and 34% by 2030.	A	-	1	Service Delivery	Finance & Performance Committee
TOTAL	21	9	8		

**-represents the moderate risks not included in the table*

Risk Appetite and Exposure

Risk Appetite

The Committee should note that while **six** sub-risks remain outside the acceptable risk threshold for their respective domains, they are being actively managed. The residual risk is subject to continuous assessment, ensuring that emerging threats and vulnerabilities are identified and addressed. To further mitigate these risks, targeted controls and interventions are continually implemented and refined, with a specific focus on reducing the likelihood, impact, or both.

Risk ID	Theme	Appetite	Threshold	Current Score
SRR 001G	Financial Sustainability	Open	17 and below	20
SRR 001I	Compliance & Safety	Minimal	8 and below	12
SRR 002A	Compliance & Safety	Minimal	8 and below	15
SRR 002B	Compliance & Safety	Minimal	8 and below	12
SRR 004B	Compliance & Safety	Minimal	8 and below	12
SRR 010	Compliance & Safety	Minimal	8 and below	12

Risk Exposure

In terms of the Health Board's current risk exposure to the **21** strategic sub-risks, the infographic below illustrates that the majority of strategic risks are concentrated in the mid to upper right quadrant of the risk matrix. This positioning reflects a high level of risk exposure, reinforcing the need for continued monitoring, robust controls, and proactive mitigation strategies to manage and reduce these risks effectively.

Risk Scoring Matrix					
Likelihood/ Frequency (Over 5 years)	Consequence/Impact				
	1. Negligible	2. Minor	3. Moderate	4. Major	5. Catastrophic
5. Almost Certain (>75%)				1 x (Extreme) *SRR 001G	
4. Likely (41-75%)					
3. Possible (11-40%)			1 x (High) SRR 007 B	13 x (High) SRR 001 A - D, F, *I, *SRR 002 B *SRR 004 B, SRR 005 A SRR 006 A, B, C *SRR 010	2 x (Extreme) *SRR 002A SRR 011A
2. Unlikely (1-10%)				4 x (Moderate) SRR 001 E SRR 004 A SRR 007 A SRR 008 A	
1. Rare (<1%)					

*Risks outside of appetite

Horizon Scanning

Recent media coverage has highlighted the potential reduction of nursing courses at Cardiff University, which presents significant risks to health organisations in Wales. These risks include workforce shortages, increased pressure on existing staff, and potential challenges to the quality of patient care. Given the already strained workforce, this development could exacerbate the healthcare crisis in Wales and lead to long-term sustainability issues for the health service.

While we currently manage a strategic risk (SRR 001A) related to workforce recruitment and retention, there is a growing concern about the impact on patient care quality and safety due to insufficient nursing staff to meet demand. This could lead to specific risks, which are being reviewed by the Director of Nursing and the Head of Corporate Risk and Assurance. They are evaluating whether a corporate risk related to professional nursing is necessary and, if so, will ensure it is reported to the Patient Quality, Safety, and Outcomes Committee for further oversight and management.

Closing Position

The closing position reported to the Committee confirms that the Strategic Risk Register currently includes **nine** high-level strategic risks and **21** sub-risks, with **six** of these sub-risks managed outside of their predefined risk appetite level. These risks continue to be actively managed to ensure appropriate mitigation and oversight

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is requested to:

- **NOTE** the Strategic Risk Register and the Risk Assessments for the 21 sub-risks, acknowledging the comprehensive review and ongoing management of these risks;
- **CONSIDER** whether it has sufficient assurance that the strategic risks are being assessed, managed, and reviewed appropriately and effectively, considering the detailed analysis and ongoing mitigation efforts outlined in this report;
- **NOTE** the risks that remain outside of the agreed-upon appetite for their respective risk domains, recognising the ongoing efforts to mitigate these risks and bring them within acceptable levels.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

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

Gwybodaeth Ychwanegol:

Further Information:

Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termiau: Glossary of Terms:	N/A

Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	At each meeting, the relevant Committee will monitor the risk theme relevant to its responsibilities.

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

				Risk Score Matrix												
Risk Description				2	4	5	6	8	9	10	12	15	16	20	25	
SRR 001	Director of workforce and OD	There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population	a)Due to an inability to recruit and retain staff across all disciplines and specialties.				X←	-----	-----	-----	-----●		◇			
			b) Due to a deterioration in, and a failure to improve, the well-being of our staff						X←	-----	-----	-----●		◇		
			c) Due to insufficient and ineffective leadership levels throughout the organisation.				X←	-----	-----	-----	-----	-----●		◇		
			d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level					X←	-----	-----	-----	-----●		◇		
	Director of Strategy, Planning and Partnerships.		e) Due to inadequate strategic plans which respond to population health and socio-economic needs				X←	-----●						◇		
			f) Due to unsustainable service models				X←	-----	-----	-----	-----	-----●		◇		
	Director of Finance and Procurement		g) Due to the failure to deliver a sustainable financial position and longer-term financial plan					X←	-----	-----	-----	-----	-----	-----◇	-----●	
			l) Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.					◇X←	-----	-----	-----	-----	-----●			
SRR 002	Chief Operating Officer	There is a risk that there will be significant failure of the Health Board's estate	a) Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	X←	-----	-----	-----	-----◇	-----	-----	-----	-----	-----●			
			b) Due to significant levels of backlog maintenance				X←	-----◇	-----	-----	-----	-----	-----●			
SRR 004	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a major incident, business continuity incident or critical incident	a) Due to emergency planning arrangements at both the corporate and operational level not being sufficiently robust to respond to a Major Incident				X←	-----●◇								
			b) Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity or Critical Incident.				X←	-----◇	-----	-----	-----	-----	-----●			
SRR 005	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a) Due to inadequate arrangements to support system-wide patient flow						X←	-----	-----	-----	-----●		◇	
SRR 005	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a) Due to inadequate arrangements to support system-wide patient flow						X←	-----	-----	-----	-----●		◇	
SRR 006	Director of Digital	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery	a) Due to the full or partial failure of existing digital infrastructure and systems					X←	-----	-----	-----	-----	-----●		◇	
			b) Due to an adverse impact on service delivery in the implementation of new digital systems				X←	-----	-----	-----	-----	-----	-----●		◇	
			c) Due to a failure to develop digital solutions that are sustainable and fit for the future					X←	-----	-----	-----	-----	-----	-----●		◇
SRR 007	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	a) Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.		X←	-----	-----	-----	-----	-----	-----	-----●		◇		
			b) Due to the impact of fragile services across the regional and supra regional geography		X←	-----	-----	-----	-----	-----	-----●		◇			
SRR 008	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff and the public	a) Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement		X←	-----	-----	-----	-----	-----	-----	-----	-----●		◇	
SRR 010	Director of Allied Health Professions and Health Science	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974	a) Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.				X←	-----◇	-----	-----	-----	-----	-----●			
SRR 011	Director of Finance and Procurement	There is a risk that the Health Board will not meet the carbon reduction target set by Welsh Government (16% reduction by 2025 and a 34% reduction by 2030) . This is common to all Health Bodies across the country.	a) The effect of a failure to meet this target is on the wider environment due to the limitations to change estate and structural operations and available funds to implement strategic changes at scale to fully meet the target expected								X←	-----●		◇		
Assessment of adequacy of assurances	POSITIVE = Identified assurances are deemed robust in telling us that the controls in place are working effectively.															
	REASONABLE = Identified assurances are deemed adequate in telling us that the controls in place are working effectively, however some gaps have been identified which need to be addressed.															
	NEGATIVE = Identified assurances are deemed insufficient in telling us that the controls in place are working effectively with substantial gaps identified which need to be addressed.															

Key	Current Score	●
	Target Score	X
	Appetite Threshold	◇
	Current to target	←

RISK THEME	PEOPLE				
SRR 001	The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.				Publication Status Public
Strategic Threat	a. Due to an inability to recruit and retain staff across all disciplines and specialties.				Risk Appetite Level – Open Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.
Impact	- Adverse impacts on delivery of care to patients across acute and non-acute settings - Non-compliance with safe staffing principles and standards - Reliance on agency and bank staff - Litigation & Financial Penalties				Risk Appetite Threshold - Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.
					SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
					Expected Date Target Score will be Achieved –
Lead Director	Director of Workforce & Organisational Development	Risk Exposure	Current Level	Target Level	
Monitoring Committee	People & Culture Committee	Likelihood	3 (Possible) x	3 (Possible) x	
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	2 (Minor)	
Last Reviewed	01 January 2025	Risk rating	= 12 (High)	= 6 (Moderate)	
Next Review (quarterly based on risk score)	01 April 2025				

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- Monitoring Framework to support roll-out of the People Plan. - Workforce Dashboard to track activity – recruitment, turnover, sickness absence. - Supply and demand tracker (Nursing and HCSW). - People Plan tracker to support delivery of actions within the People Plan 2022-25. - Variable Pay Reduction Plan approved June 2022 and supported by the Programme Board. - Management of attendance through All Wales Management Attendance at Work Policy. - Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture. - Nurse Staffing Levels (Wales) Act 201625b/25c. - Review of staffing and recruitment plan internally in line with Royal College Guidance, i.e., RCP. - Workforce planning supported by Compendium of new roles to support innovative workforce models. - Recruitment KPI's. - IMTP (Integrated Medium-Term Plan) Educational Commissioning. - Workforce Establishment controls national working group has been instigated. - Value and Sustainability Board. - Collective Agreement (Non-Pay Deal) 2022/24 Recruitment - Engagement with national recruitment campaigns such as BAPIO, M&D Kerela Initiatives, Train, Work, Live and Student Streamlining for Registered Nurses, Physician's Associates, Midwives, and therapy staff and with HEIW (Health Education and Improvement Wales) for Junior Doctor. - Annual programme of Apprentice recruitment - Overseas Nursing (All Wales Recruitment programme) - Nursing Workforce Strategy agreed. - Streamlining and improving recruitment timescales through recruitment modernisation programme (started Oct 2022) - Partnerships with employability schemes and FE/HE to widen access. - Actively working with Local Authorities to promote joint recruitment activities via Gwent Workforce Board.	Retention - Development of career pathways (e.g., non-clinical to clinical). - NHS Wales Nurse Retention Plan quarterly updates being reviewed for submission 09 Sept 2024 - Short project in progress with an MSc student to develop a retention dashboard, using a regression model to better understand and predict retention. Data analysis is underway with a 5 year past dataset shared. Variable Pay Reduction - Development of action plan based on WHC to support the reduction in bank and agency usage. E- Systems - Utilise benefits of roll out Safe Care staffing to support effective and efficient staff deployment within adult ward areas. - Roll out of medical rostering to predict junior doctor gaps and look for alternative ways to fill. - Ensure compliance increase in e-job planning to optimise current resources and identify any gaps in provision. - Review and analyse the electronic Bank & Agency data from Patchwork to identify areas with high usage, reasons for use and potentially convert to substantive roles. Development of alternative and new roles - Continued implementation of new roles such as Physician Associates, CAAPs, Enhanced and Advanced roles to support workforce skills gaps in line with IMTP. - Establishment of Mental Health Workforce Planning through HEIW leadership of Mental Strategic Workforce Plan and allocation of workforce planning resources and training programme currently being delivered to Health Boards. - Updating of compendium of new roles and benchmarking is available via workforce planning intranet site and HEIW portal.

- Working with partners to improve visibility and attraction - DBS Policy in place with DBS risk assessment form Retention - Retention lead appointed with programme action plan in place for the next two years. - Engagement chat cafes providing information and support for key topics such as Agile Working, Learning and Development, Wellbeing Activity, Occupational Health, and Complex HR. - Week of events planned to support retention agenda in June 2024. This will include a mixed method of online webinars, videos and retention materials. - Internal Retention group has been established with a view to 1) interrogating data from multiple sources to fully understand the issues 2) Turn the data into intelligence so that we can understand and respond to organisational and local level impacts. - Changes in pension regulation and flexile retirement options from October 2023 and reduced break in service required following retire and return. - Development of HCSW skills matrix and career framework has commenced. - Talent management and succession planning framework and resources now live and available on SharePoint. Framework signed off by Executive Committee. - Career conversations and succession planning resources designed; workshop dates available with spaces for 120 people (with monthly training sessions available). Sessions are nearly fully booked with 114/120 places booked. - All Wales self-assessment retention tool completed and submitted to HEIW with assessment at organisational level for Nursing and Midwifery to provide a baseline. Variable pay reduction - Plan in place to monitor and review all agency, bank pay incentives supply and demand reporting to Value and Sustainability Board. E- Systems - Effective deployment of current staff - Programme Plan implemented to introduce Workforce Medical E-Systems to support effective deployment of medical staff. E-Locum Bank, E-Job Planning, E-Agency systems are all ‘live’ and rolled out within the Health Board. - E-Rostering is planned to go live shortly following ESR interface testing, provisionally scheduled for the end of January 2025. - Development of alternative and new roles - A Gwent Strategic Workforce Action plan has been developed through co-production with our partners across Gwent, and now forms the basis of the Gwent Workforce Board programme of work and agenda. The Action plan has been developed around the 7 key principles of A Healthier Wales: Our Workforce Strategy for Health and Social Care - The NCN (Neighbourhood Care Networks) Workforce Planning programme commenced in Autumn 2023, with all initial workforce planning workshops with all 11 NCN areas completed. The programme is now moving into the next stage of the programme with a comprehensive workforce planning assessment of Blaenau Gwent as an initial project. Programme plan led by WOD developed in conjunction with NCN leads and Divisional Senior Management. Training - The HEIW Education & Training Plan continues the investment in education and training in Wales that has been increasing over past years. In the HEIW Education Training Plan 22/23 there were increases in - Adult Nursing (36%) and Mental Health Nursing (20%), Healthcare science, Allied Health Professionals Clinical Psychology (11%- 43%). This will increase the number of graduates coming out of training in 2025 and beyond which are required to support turnover and existing vacancies in addition to external recruitment and internal training developmental programmes. - The 2024/25 education training plan demonstrated very few increases on previous years for students graduating in 2027 and beyond. The draft 2025/26 education and training plan proposes further increases in Wales training numbers in all branches of Nursing, health care science, medical speciality training junior doctors, pharmacy and continued increase in HCSW investment and increased placements in adult nursing in General Practice. - HEIW have increased Health Care Support Workforce Development funding and there have been further changes for accelerated training pathways in some areas so support entry graduate level qualifications. Improved HCSW funding has enabled clinical induction to be delivered in house from April 2024 to accelerate time to effectiveness and improve employee experience. - RCN Connect Programme has been established in connection with HEIW and higher education providers to support candidates enter registered nursing training (12 supported so far this year, with 3 more to interview) - Cadet Nursing programme in place – 16 candidates attended for the 2024 induction and work is ongoing to support all 16 to achieve accreditations. - K102 bridging model now being offered to support HCSW pathways into registered nursing. - Development of Leadership Development programmes for key roles such as the Clinical Director post (CDx) is in its second year. Similar program for Directorate Managers (DMx) a 10-month leadership development program to support the capability of this key group commenced 23 April 2024. Nursing and Midwifery Academy for senior level nurses and midwives, Leadership Development program (entry level) and Leading People (advanced Level) programmes fully booked. Core Leadership programme currently delivering to 200 staff. - Delivery of workforce planning training	- Looking to increase Assistant band 4 in Community/Mental Health and areas such as Cardiology Physiology - Continue to extend scope of Advanced Clinical Practitioners to undertake new procedures, reporting etc reducing medical capacity. - Increasing consultant therapy and nurse practitioners. - RCN introduction of Registered Nursing Associate role to help build the capacity of the nursing workforce – students to start from September 2025 with placements from September 2027. - Development of new roles and career pathways to support hard to fill roles in Health Visiting. - Re-design of the Health Board’s work experience programme with 246 applicants since March 2024 and 75 placements confirmed Training - HEIW are increasing the capacity of training through creating more spaces for training the future Primary Care workforce, including Primary Care Academy - Workforce planning training prospectus of local and online training launched September 2024 - Development opportunity being scoped for Business support staff. - Suite of learning masterclasses launched with 5 topics now available to book, including influencing skills, setting up teams for success, giving feedback, having courageous conversations, having a meaningful PADR. 236 attendees in July 2024. - Recruitment training for managers to streamline campaigns as much as possible to reduce time to hire. - Development of training doctor fill rate dashboard to monitor and improve fill rate or to inform alternative recruitment strategies. - A review and action plan underway to consider how to address instances where nurse streamlining preferences for specific posts exceed the number of vacancies available, to promote recruitment and retention. 31 staff enrolled on workforce planning on line training modules level 1. 15 managers enrolled on level 2 training delivered locally March 25.

Vacancy Numbers and establishment control - Quarterly reporting of vacancy numbers for each staff to the WG as of 30th September 2024 were 585 WTE a reduction of 51 WTE since March 2024. - Development of ESR establishments commenced on a national basis w/c 03 September 2023. Local delivery action plan has been developed and project workstream established and work commenced. National work programme proposal is also in development to assess digital solutions Staff attendance - Support for staff who are absent in line with Managing Attendance at Work Policy, including those on long term absence with a view to signposting to self-help support, and adapting/adjusting roles to enable a safe return to work. “Hot spot” areas identified and plans in place to support	

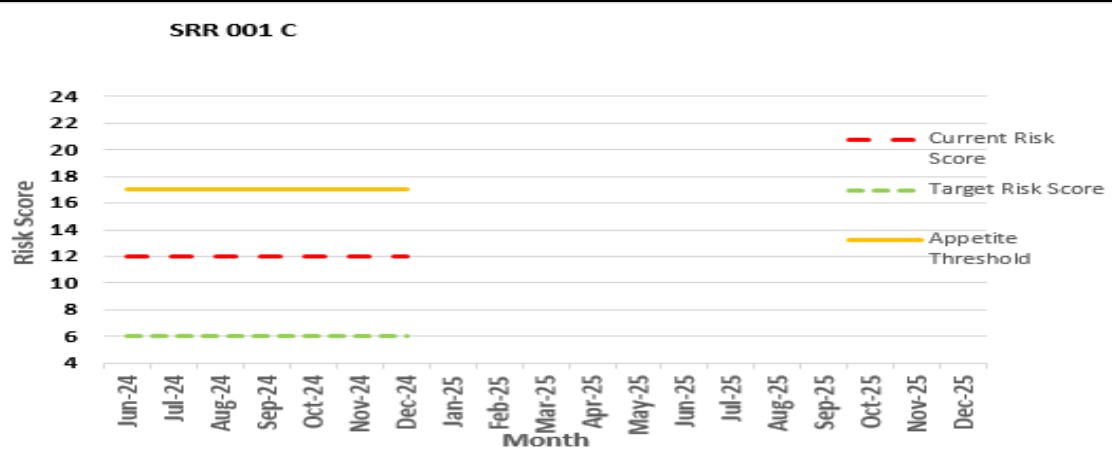
Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- Workforce reports to the Nurse Strategic Workforce Group. - Monthly sickness monitoring reports. - Weekly filled and unfilled shift reports (RN) and reports of agency for HCSW/RN. - Medical Staffing Co-ordinator review of medical rotas. - Cross site operational calls. - Occupational Health and Wellbeing dashboards report KPIs. - Recruitment KPIs - Medical & Dental and Student Streamlining fill rate reports			
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- Reports to the People and Culture Committee and the Board on the progress of the People Plan 2022-25 - Workforce Dashboard presented to the Executive Committee, P&CC Committee, and the Board. - Workforce and OD (Organisational Development) group established to support delivery and implementation of workforce plans to support Clinical Futures Service transformation. - Measurements of Wellbeing through the ABUHB (Aneurin Bevan University Health Board) Staff Survey - Routine Reporting against nurse staffing levels. - Variable Pay Programme Board reporting to Value and Sustainability Board			
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
- Internal Audit Reviews 2023 -24 - Long Term Sickness Absence Management (Q4) - Flexible Working (Q4) - External quarterly vacancy reporting to WG - External reporting on Nursing Staffing Levels - National Acuity Audits (Nursing) - National Workforce Implementation Plan: Addressing NHS Wales Workforce Challenges. The Strategic Workforce Implementation Board will report to the Minister for Health and Social Services with a collective view from a range of key partners including policy and professional leads in WG, and representatives of NHS employers, staff organisations and professional representative. - Workforce planning external audit action plan 2024	Latest local survey saw a reduction in staff wellbeing	Internal Audit Staff Culture Q3 2024/25	
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>			
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Positive Assurance

RISK THEME	PEOPLE			
SRR 001	The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.			Publication Status Public
Strategic Threat	b. Due to a deterioration in, and a failure to improve, the well-being of staff.			Risk Appetite Level – OPEN Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.
Impact	- High absence levels, with some sustained long periods - Adverse impacts on delivery of care to patients across acute and non-acute settings - Non-compliance with safe staffing principles and standards - Reputational damage to the health board as an employer - Work-related claims - Financial Implications			Risk Appetite Threshold - Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.
				SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
				Expected Date Target Score will be Achieved –
Lead Director	Director of Workforce & Organisational Development	Risk Exposure	Current Level	Target Level
Monitoring Committee	People & Culture Committee	Likelihood	3 (Possible) x	3 (Possible) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	3 (Moderate)
Last Reviewed	01 December 2024	Risk rating	= 12 (High)	= 9 (High)
Next Review (Quarterly based on risk score)	01 March 2025			

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
General - Monitoring of absence, reasons for absence and trends in referrals to Occupational Health and Employee Well-being Service through Workforce Performance Dashboard. - Dashboard reported to Executive Team, TUPF and LNC colleagues and People and Culture Committee with regular summary of Well-being and Occupational Health activity. - Regular meetings with divisions to ensure staff are well supported and staff wellbeing is a priority. - Strategic Equality plan - Rest and Facilities charter – monitoring and compliance. - Staff related policies. - National Staff Survey and Health Board Employee Experience Survey - External Employee Assistance Programme - Speaking up Safely action plan - Race/LGBT groups. - Wellbeing resources - Staff diversity networks - Regular Schwartz rounds arranged across the Health Board - Taking Care giving care Rounds integrated into our leadership offers and available for teams to undertake either with support or on their own. - Close links with the Arts in Health programme - Chaplaincy service for staff - Establishment of new bilingual Health and Well-being AB Pulse page on the intranet with library of resources for staff well-being Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate. - Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management. - The Avoidable Employee Harm Programme, launched on 05 July 2022 initially focusing on HR processes has resulted in a 70% reduction in investigations and a wide range of other organisational benefits - The Avoidable Employee Harm Programme model will be used to underpin our approach to the Speaking up Safely (SUS) initiative within ABUHB.	General - Increase wellbeing initiatives. - Identify, training and develop Respect and Resolution advocates (like Mental Health first aiders). - Work with Professional Nurse Advocates (PNA) to explore ways to offer high quality support to nursing colleagues. - Trained mediators so there is team and organisational resilience and network. - Scope, design and deliver a programme of research ‘Healthy Working Day’. - Enhanced our financial well-being offer. - Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate. - Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management. - The Avoidable Employee Harm Programme, launched on 05 July 2022 initially focusing on HR processes has resulted in a 70% reduction in investigations and a wide range of other organisational benefits. The programme has now won six awards including two from NHS Wales. Occupational Health. - Reviewed Occupational Health provision and consider options to improve sustainability within the service, paper drafted. - Submission of response to All Wales KPI delivery and ongoing data analysis review in place. - Recently appointed 8a role to provide further clinical leadership and key priority for M1-3 is to undertake training needs analysis to develop OH team. - Support equality and diversity of workforce. - Review of staff diversity networks. - Review of wellbeing survey through and equality lens to understand variations within diverse workforce demographic profile. - Development of a buddy system to assist international medical staff with induction and orientation and support values and current norms. - Development of an empowerment passport to support disabled staff and reasonable adjustments and wellbeing.

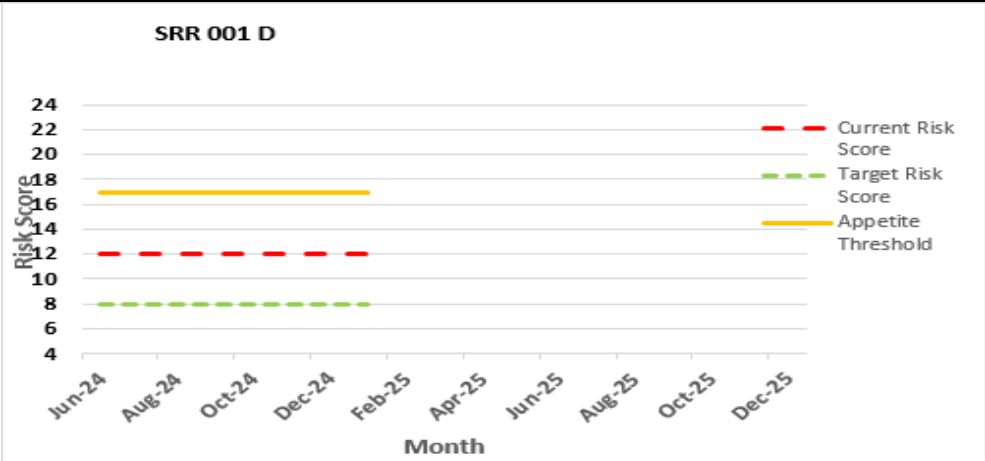
- an externally commissioned SUS hotline will be piloted in September 2024. - An external Employee Assistance Programme (Vivup) has been commissioned for 12 months to offer additional psychosocial wellbeing support to staff, including a waiting list initiative. Waiting times have now reduced on average by 30%. Occupational Health - Additional occupational health resources secured to reduce waiting times. - Occupational Health and NWSSP are working in partnership to implement a new Occupational Health Software system across Wales called OPASG2. OPASG2 provides benefits to employment and recruitment processes. - Occupational Health and the Well-being Service continue to work with Therapies colleagues on support for staff experiencing Long Covid-19. - Support equality and diversity of workforce. - A part time Disability Inclusion Officer has been seconded to the EDI Team (December 2023 – December 2024). - Band 5 EDI Officer appointed and commence in post at the end of March 2024. - Inclusive Leadership sessions embedded in the Leading People Programme from January 2024 onwards. - Reverse Mentorship Programme launched February 2024. Other - Assessment of compliance against BMA Rest and Facilities charter complete with action plan developed, reporting to LNC - Reducing fatigue poster developed.	

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		
- Dashboard reporting - Reporting to monitor the rollout of the People Plan 22-25 - Reporting to monitor of demand on wellbeing services	Understand if support is reaching all staff	Meetings with Divisions ongoing to ensure all areas are aware of what’s available.
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>		
- People and Culture Committee reports (People Plan 22-25) - Local wellbeing surveys - LNC – reporting of compliance of BMA Rest and Facilities		
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>		
- National workforce surveys - Monitoring and compliance of BMA Rest and Facilities via NHS Employers - Staff Welfare Charter - Sickness Absence Audit 2023/24 – Outcome: Reasonable Assurance	Latest local survey saw a reduction in staff wellbeing	Internal Audit Staff Culture Q3 2024/25
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>		
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.
Positive Assurance		

RISK THEME	PEOPLE			
SRR 001	The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.			Publication Status Public
Strategic Threat	c. Due to insufficient and ineffective leadership levels throughout the organisation			Risk Appetite Level – Open Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.
Impact	- Adverse impacts on delivery of care to patients across acute and non-acute settings; - Failure to deliver health board priorities, required improvements and achieve sustainability; - Poor levels of accountability and delivery; - Reputational damage to the health board as an employer; - Adverse impacts on staff recruitment and retention			Risk Appetite Threshold - Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.
				SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
				Expected Date Target Score will be Achieved –
				
Lead Director	Director of Workforce & Organisational Development	Risk Exposure	Current Level	Target Level
Monitoring Committee	People & Culture Committee	Likelihood	3 (Possible) x	3 (Possible) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	2 (Minor)
Last Reviewed	01 December 2024	Risk rating	= 12 (High)	= 6 (Moderate)
Next Review (Quarterly based on risk score)	01 March 2025			

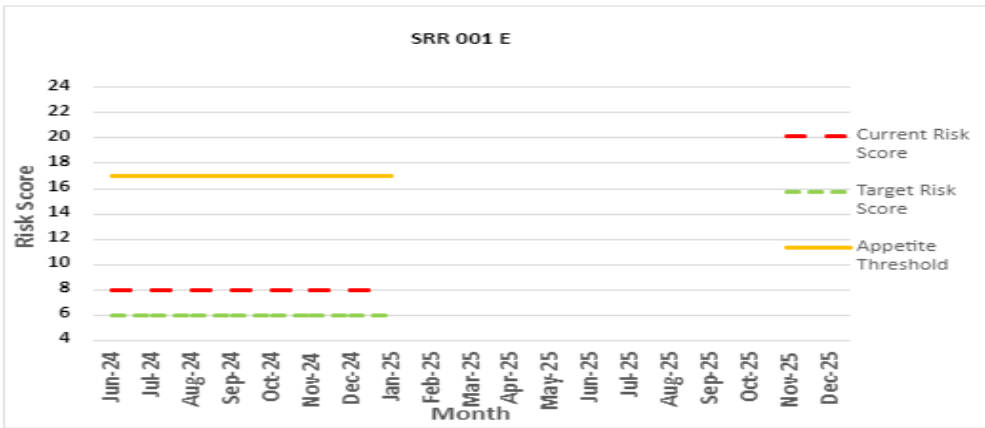
Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- Talent and Succession Planning - Monitoring Framework to support roll out of the People Plan – Focus on Talent and Succession Planning. - Monitoring Frameworks with HEIW - Lead appointed July 2023 on secondment funded by HEIW to create organisational talent management framework to enable to organisation to be deliberate and consistently attract, identify and develop talent for critical roles across ABUHB. - HEIW schemes 1 x HEIW funded graduate managements trainee successfully appointed August 2023 following additional recruitment process. - Develop Leadership Capabilities - Leadership journey and programmes mapped and 1 pager flyer designed and on intranet. Leadership development offer now available for entry level leaders and mangers, clinical directors, directorate manager development programme DMx to launch Q1 2024/25, senior nurses and multi-disciplinary teams. - Learning masterclasses have been designed and developed for the organisation addressing ley themes such as giving feedback, developing team and having courageous conversations. - Leading people programme (starting cohort 8 may 2024) 2022/2024 Academi Wales scheme the Health Board are sharing a graduate with Monmouthshire council; our graduate joined the health board in March 2023 and is supporting the decarbonisation agenda.	Talent and Succession Planning - Pilot planned for Finance, Occupational Health and divisional managers focusing on how to identify critical roles, development sessions on holding career conversations and culminating in a Talent Management Strategy. Development leadership capabilities - Currently exploring leadership funding options with USW in order to maximise Governmental Grants and utilisation of the apprentice levy. - Continued commitment to NHS graduate schemes.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		
- WOD Divisional reporting - Evaluation of internal leadership programmes and regular review of our internal offer		
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>		
Reporting to People and Culture Committee - progress against People Plan 22-25		
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>		
- Internal Audit Review - Talent and Succession Board		
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>		
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.
Positive Assurance		

RISK THEME	PEOPLE				
SRR 001	The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.			Publication Status	Public
Strategic Threat	d. Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level			Risk Appetite Level – Open Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	- Adverse impacts on delivery of care to patients across acute and non-acute settings - Non-compliance with safe staffing principles and standards - Litigation & Financial Penalties - Reputational damage to the health board and loss of public confidence			Risk Appetite Threshold - Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.	
				SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
				Expected Date Target Score will be Achieved –	
					
Lead Director	Director of Workforce & Organisational Development	Risk Exposure	Current Level	Target Level	
Monitoring Committee	People & Culture Committee	Likelihood	3 (Possible) x	3 (Possible) x	
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	4 (Major)	
Last Reviewed	01 December 2024	Risk rating	= 12 (High)	= 8 (Moderate)	
Next Review (Quarterly based on risk score)	01 March 2025				

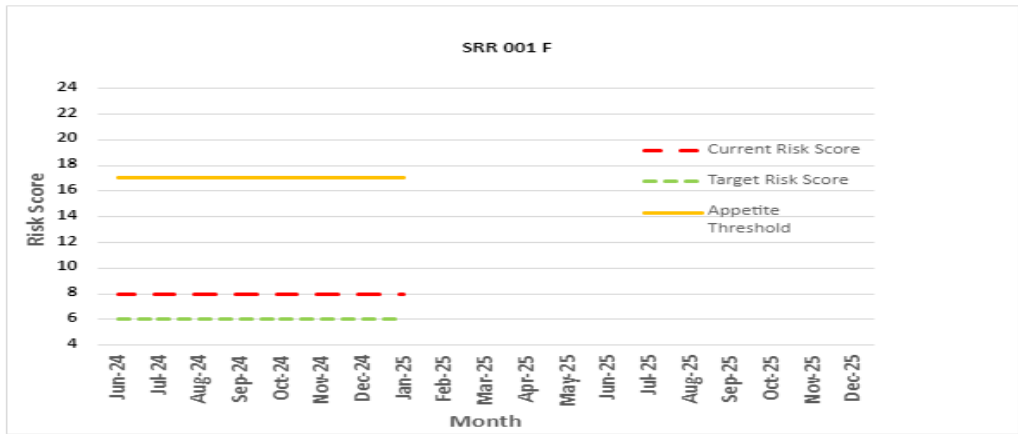
Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- All Wales Industrial Action Planning Group - Local Health Board planning arrangements - Section 234A of the Trade Union and Labour Relations (Consolidation) Act 1992; and - CODE OF PRACTICE Industrial Action Ballots and Notice to Employers - Business Continuity Processes - Redeployment Principles and Risk Assessment agreed. - Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture - Effective derogation processes including Christmas Day cover definition. - Local Negotiating Committee (LNC) - Services Business continuity plans in place. - Terms and conditions agreements in place for medical cover supported by NHS Wales Employer guidance. - Command and control structure and leads established. - Derogation test completed. - Executive and Senior Manager leads established links with national planning cells. - All Wales training sessions provide by legal and risk to support industrial action. - Reducing impact on patients - Support for early supported discharge prior to industrial action. - Picketing guidance supported and agreed	- Agreement reached in England for Medical & Dental Staff – re-commencement of negotiations in Wales for Medical & Dental Staff. - Issue of WHC AFC non pay elements of collective agreement 2022-24. Response to WG on immediate assurance by end May 2024 - Review of rotas for junior doctor industrial action (minimum staffing levels based on safety assessment). - Communication plans- public, stakeholders and partners - Establish working mechanisms with NWSSP to consider derogations for junior doctors (who are the employer) and pay application. - Consideration of further additional national legal advice

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		
- Local Staff re-deployments assessment - Divisional engagement and service planning arrangements in place - Local Negotiating Committee (LNC) - Trade Union Partnership meetings		Further industrial action
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>		
- Reporting to Executive team - Business Continuity groups - Command and control structure in place to be implemented as required.		
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>		
- All Wales IA group and Welsh Government planning group. - Debriefing session planned to reflect and capture learning for any potential future action		
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>		
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively. Reasonable Assurance

RISK THEME	SERVICE DELIVERY					
SRR 001	The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.				Publication Status	Public
Strategic Threat	E. Due to inadequate strategic plans which respond to population health and socio-economic needs.				Risk Appetite Level – Open Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	- Increased demand - Increased patient acuity levels - Worsening of health inequalities - Worsening of health outcomes - Failure to train teams in multi-morbidity management - Failure to comply with the Wellbeing of Future Generations Act (Wales) - Reputational damage and loss of public confidence				Risk Appetite Threshold - Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.	
					SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
					Expected Date Target Score will be Achieved –	
						
Lead Director	Director of Strategy, Planning and Partnerships.	Risk Exposure	Current Level	Target Level		
Monitoring Committee	Partnerships, Public Health & Planning Committee	Likelihood	2 <i>(Unlikely)</i> x	2 <i>(Unlikely)</i> x		
Initial Date of Assessment	01 June 2023	Impact	4 <i>(Major)</i>	3 <i>(Moderate)</i>		
Last Reviewed	01 September 2024	Risk rating	= 8 <i>(Moderate)</i>	= 6 <i>(Moderate)</i>		
Next Review (Six-monthly based on risk score)	01 March 2025					

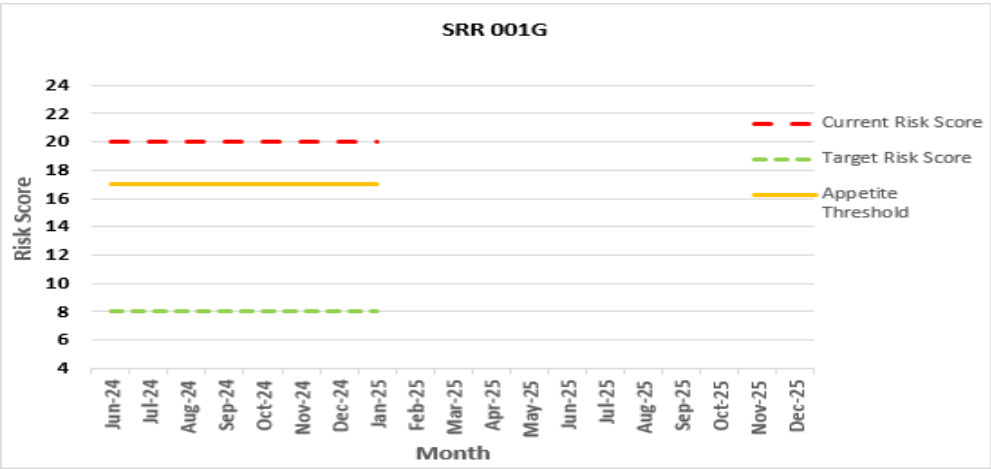
Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- Health Board IMTP and associated KPIs - Public Health Wales surveillance data - QlikSense – performance dashboard - Population Needs Assessment and Area Plan - Marmot Region Programme	- Area plan is being refreshed through the RPB - Marmot Region Implementation Plan - Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. - Refresh organisational strategy with a central focus on population health and wellbeing. - Action through SEW Regional Collaborative to identify additional service areas where collaboration and networking would support sustainability.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- QlikSense – performance information - SFN – performance information			Effectiveness of the plans in delivering improvements
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- IMTP Delivery and Outcomes Reporting to Board - Marmot Region Programme - RPB reporting to Board and Population Health, Planning and Partnerships Committee - Regional Planning reporting to Population Health, Planning and Partnerships Committee - Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee			Outcome of the Internal Audit Partnership Arrangements scheduled for Q1 2024/25 Plan
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
- Internal Audit Reviews 2023-24 - IMTP Planning (Q1) Outcome – Reasonable Assurance			
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>			
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable Assurance

RISK THEME	SERVICE DELIVERY					
SRR 001	The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.				Publication Status	Public
Strategic Threat	F. Due to unsustainable service models				Risk Appetite Level – Open Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	- Increased demand - Increased patient acuity levels - Worsening of health inequalities - Worsening of health outcomes - Failure to train teams in multi-morbidity management - Failure to comply with the Wellbeing of Future Generations Act (Wales) - Reputational damage and loss of public confidence				Risk Appetite Threshold - Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.	
					SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
					Expected Date Target Score will be Achieved –	
Lead Director	Director of Strategy, Planning and Partnerships.	Risk Exposure	Current Level	Target Level		
Monitoring Committee	Partnerships, Public Health & Planning Committee	Likelihood	2 (Unlikely) x	2 (Unlikely) x		
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	3 (Moderate)		
Last Reviewed	01 September 2024	Risk rating	= 8 (Moderate)	= 6 (Moderate)		
Next Review (Six Monthly based on risk score)	01 March 2025					

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- The Health Board IMPT and associated KPIs - Clinical Futures Transformation programmes. - Public Health Wales surveillance data – Covid, flu and other communicable diseases. - QlikSense – performance information. - Population needs assessment and area plan development by the RPB. - Southeast Wales Plan for fragile services.	- Area plan is being refreshed through the RPB. - Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. - Review of enhanced local general hospital service models to ensure sustainable quality services. - Development of SEW plan for fragile. - Review of organisational strategy – to launch Summer 2024.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		
- Public Health Wales surveillance data – COVID, flu and other communicable diseases. - QlikSense – performance information.		Evidence of individual arrangements in place to deliver service plans.
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>		
- IMTP delivery and outcomes reporting to Board. - RPB reporting to Board and Population Health, Planning and Partnerships Committee. - Regional Planning reporting to Population Health, Planning and Partnerships Committee. - Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee.		Outcome of the Internal Audit Partnership Arrangements scheduled for Q1 2024/25 Plan
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>		
Internal Audit Reviews 2023-24 - IMTP planning Q1. Outcome – Reasonable Assurance. Internal Audit Reviews 2024-25 - IMTP – Service Plans (Q2)		
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>		
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.
Reasonable Assurance		

RISK THEME	FINANCIAL SUSTAINABILITY				
SRR 001	The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.			Publication Status	Public
Strategic Threat	G. Due to the failure to deliver a sustainable financial position and longer-term financial plan.			Risk Appetite Level – Open Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	- Breach of statutory duty to breakeven over 3 years. - Instigation of NHS Wales Escalation & Intervention Arrangements. - Non–delivery of health board priorities, required improvements, and achieving longer-term sustainability. - Prioritisation and possible disinvestment in service delivery. - Reputational damage and loss of public confidence			Risk Appetite Threshold - Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.	
				SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
				Expected Date Target Score will be Achieved –	
					
Lead Director	Director of Finance and Procurement	Risk Exposure	Current Level	Target Level	
Monitoring Committee	Finance & Performance Committee	Likelihood	5 (Almost certain) x	2 (Unlikely) x	
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	4 (Major)	
Last Reviewed	01 December 2024	Risk rating	= 20 (Extreme)	= 8 (Moderate)	
Next Review (Monthly based on risk score)	01 January 2025				

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- IMTP 2023/24-25/26 - IMTP Delivery Framework - Accountability Framework - Performance Framework - Scheme of Delegation - Standing Financial Instructions (SFIs) - Standing Orders (SOs) - Final budget delegation - Financial Control Procedure (FCP) Budgetary control - Financial Budget Intelligence (FBI) - Appropriately trained Finance Team (capacity & capability) - Budget holder training - Cost intervention procedures 23/24 savings plans & opportunities. - Health Board financial escalation processes. - Health Board Pre-Investment Panel (PIP) process. - Financial assessment and review to incorporate the financial impact of COVID-19 and other key costs. - Executive groups and structures established to deliver statutory duties. - Assessment of financial control environment within divisions and corporate teams. - Financial Escalation Meetings - Regular organisational Recovery plan meetings and briefings - Value & Sustainability Board established.	- Revised V&SB approach for 2024/25 to help drive financial recovery, separating thematic and divisional scrutiny. - Focus on future opportunity development to deliver 3-year financial plan – through programmes under the VS&B structure.

- Revised accountability arrangements part of Executive governance. 3-year route map to sustainable recovery developed and approved by Board July 24.		
Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		
- Adherence to SO/SFI/FCPs - Regular AFD meetings to discuss position and performance. - Divisional Assurance meetings are in place to implement savings plans and deliver service and workforce plans within available resources – part of Chief Operating Officer governance.		- Greater focus is required on service, workforce, and financial plans all balancing to achieve financial sustainability. - Development of detailed 3-year recovery plan.
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>		
- Regular monitoring at the Executive Team reviewing the level of deliverable recurrent savings along with assessing cost avoidance and deferred investments. - Performance escalation meetings established. - Financial assessment and review report to the Board and Finance & Performance Committee - Financial Governance and Accounting reports to the Audit, Risk and Assurance Committee. - Board Briefing sessions on the financial position. .		2024/25 IMTP plans focussed on ‘living within’ budget levels. 2024/25 savings plan to be delivered. - Detailed delivery plans will be a constant development over next 2 years.
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>		
Internal Audit Reviews 2023-24 - IMTP planning Q1. Outcome – Reasonable Assurance. Internal Audit Reviews 2024-25 - IMTP – Service Plans (Q2)	Internal Audit Reviews 2023 – 24 - Savings Programmes – Reported to ARAC - Reasonable Assurance - Financial Controls – Reported to ARAC July 2024 – Substantial Assurance - Asset Management Q3 – Reported to ARAC April 2024 - Reasonable Assurance External Audit Reports 2023 -24 - Efficiency Review 23/24 Q3/Q4 – Not yet reported. - Structured Assessment - Received at ARAC November 2023. - Audit of Financial Statements Q4 2023/24 – True & Fair view given, minor recommendations, qualified on deficit and 3-year IMTP not agreed. - Financial assessment and review reports to Welsh Government – monthly - Enhanced monitoring T.I. meetings with Welsh Government – monthly	
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>		
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively. Reasonable Assurance

RISK THEME	COMPLIANCE AND SAFETY																																																																																					
SRR 001	The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.				Publication Status	Public																																																																																
Strategic Threat	i. Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.				Risk Appetite Level - MINIMAL Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.																																																																																	
Impact	- Unintended patient harm - Negative patient/public experience - Loss of patient/public trust and confidence - Reduced staff morale leading to potential absence from work - Scrutiny from external organisations (AW/HIW/WG) - Punitive Action - Adverse publicity - Financial implications				Risk Appetite Threshold – SCORE 8 AND BELOW Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.																																																																																	
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Monitoring Committee	Finance & Performance Committee	Likelihood	3 <i>(Possible)</i> x	2 <i>(Unlikely)</i> x																																																																																		
Initial Date of Assessment	19 April 2024	Impact	4 <i>(Major)</i>	4 <i>(Major)</i>																																																																																		
Last Reviewed	01 December 2024	Risk rating	= 12 <i>(High)</i>	= 8 <i>(Moderate)</i>																																																																																		
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Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- Performance Management and Assurance Framework - Executive Accountability letters - Divisional Directors Accountability letters - Monthly Assurance meetings with fortnightly meetings for Urgent Care and MH&LD Divisions in place - Escalation processes triggered for Divisions in escalation – including improvement plans and fortnightly oversight (as above) with agendas that focus on priority areas. Reviewed post End of Year and proposed adjustments awaiting sign off - Reporting through to Finance and Performance Committee via Executives - Specific areas of focus are discussed at Value and Sustainability Board - System wide way of working to progress an operational framework, develop winter plans, escalation processes, etc. - External scrutiny via Welsh Government and NHS Executive	6-month review of Performance Management and Assurance - Alignment of internal mechanisms to national escalation - Focussed agendas targeting specific areas of concern and areas for improvement – working with the Business Partners to ensure a joined-up approach. - Standardised Divisional Assurance Templates (pre-populated) - Commission external reviews to support improvements where required. - Appropriate Business Partnering Support and analytical support - Realign capacity and/or redefine roles to provide explicit support

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- DMTs in place for all Divisions - Divisional oversight arrangements – monthly/fortnightly meetings - Divisional plans in place and focussed agendas - Cross Divisional meeting monthly – progress the wider system way of working. - System Leadership Team for awareness and updates - Capacity to run the performance framework and reporting requirements has been strengthened with the appointment of the Head of Systems Planning and Performance and analytical team who will fully be in place by January 2025 alongside the Business Partnering Support		12-month Performance Management Framework review in the Autumn	Internal Audit 2024/25 Plan - Findings and recommendations from the Divisional Governance Arrangements (Q2) - Findings and recommendations from the Directorate Review - Mental Health and Learning Disabilities (Q2)
• Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- Established reporting to the Executive Committee - Established reporting to the Finance and Performance and Patient, Quality and Safety Committee - Established reporting to the Board - Routine reporting through the IQPD process			
• Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
- Internal Audit 2024/25 Plan - Directorate Review - Mental Health and Learning Disabilities (Q2) - Divisional Governance Arrangements (Q2) - HIW Inspections - Llais for feedback			
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>			
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable Assurance

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

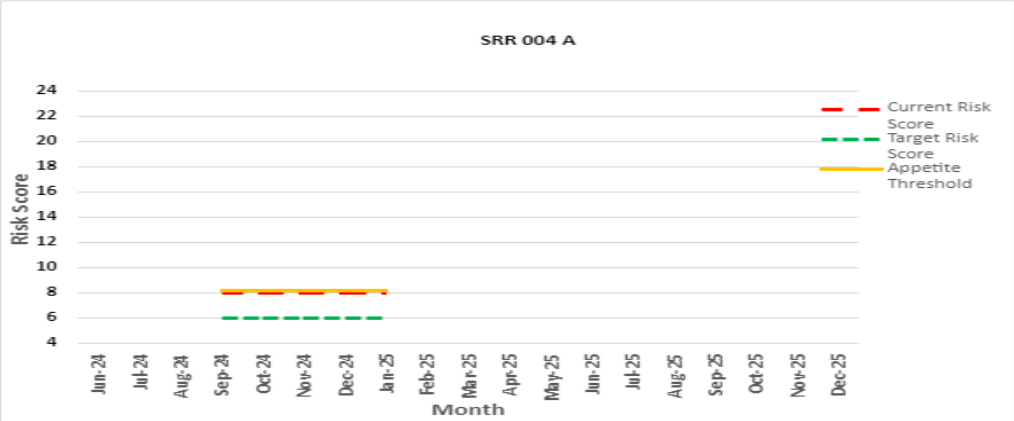
Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- Work to assess the risk has been undertaken with expert external surveyor advice. Repeat surveys undertaken on 6 monthly intervals (most recent June/July2024 with report detailing recommendations received in October 2024). Next round of surveys will be December 2024 to January 2025 - Current measures including props and additional support have been put in place in line with the latest guidance and learning from other organisations working through RAAC issues. Plans will be modified in line with any further guidance - Remediation work to areas of high-risk areas undertaken - Controlled access to roof areas - Implemented toolbox talks for awareness for estate teams and contractors to work in area where RAAC is present. - Ongoing engagement with expert surveyor - Estates and Facilities Divisional Compliance team engaged in supporting the estate's function response to the ongoing management - Risk assessments completed by the Health and Safety function in departments with props to manage any consequences of the presence of props. <i>Note: H&S assessments are around the location of props not of RAAC itself and they flagged no issues or alterations</i> - Links with NHS England and other Health Boards in Wales for shared learning. Regular dialogue with Welsh Government and Shared Services Estates.	- Additional Surveys continue to take place with expert surveyors to inform the next steps relating to further remediation of the issues and monitor existing issues - Review of existing arrangements to monitor, manage and mitigate issues associated with RAAC is underway with external support and advice from the surveying contractor based on their experiences in NHS England and education bodies. This will inform any additional steps to monitor manage and mitigate led by the RAAC Working Group (chaired by the Director of Estates and Facilities Division)

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- Fortnightly checks in place for the props in place - Outcome of surveys continuing, and reinspection of conditions (a regular 6 monthly inspection) - Review of existing arrangements in place supported by external body		Ongoing management of the issues.	- Repeat surveys have been completed and once the latest report from these surveys is received any necessary additional actions will be implements Internal Audit 2024/25 Plan - Review of existing governance arrangements– undertaken with external advisors and final version of review will be received alongside the Management Strategy in December 2024
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- Health Board Fire and Health and Safety function engaged in fortnightly governance group to monitor risks and issues associated with any remedial measures implemented. - Outcome of H&S risk assessment - Formal reporting to the Board/Committees in place - Formal update to the PPHPC in July with full SOC end of Q3.			
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
- Internal Audit 2024/25 Plan – report received as Reasonable Assurance (albeit Substantial Assurance on the process relating to surveys. Report submitted to Audit Committee November 2024. - Management Action Plan agreed following Internal Audit including the development of a Management Strategy. This is in draft and will be concluded December 2024 for discussion with the RAAC Group in January 2025. - Internal Audit also commented that the risk appetite needs to reflect the current position of monitoring and managing the RAAC pending SOC and FBC hence appetite of 15 should be considered by Board.			
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>			
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable Assurance

RISK THEME		COMPLIANCE AND SAFETY											
SRR 002		There is a risk that there will be significant failure of the Health Boards Estates.								Publication Status		Public	
Strategic Threat		b. Due to significant levels of backlog maintenance and structural impairment.					Risk Appetite Level – MINIMAL Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.						
Impact		- Harm or injury to patients and/or staff. - Adverse impacts on the delivery of care to patients across acute and non-acute settings. - Non-compliance with health and safety legislation. - Litigation and financial penalties. - Litigation and financial penalties. - Loss of estate					Risk Appetite Threshold – SCORE 8 AND BELOW Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.						
							SUMMARY The current risk level is OUTSIDE of the target level and appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.						
							Expected Date Target Score will be Achieved –						
							SRR 002B </						

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- Health Board Estates Rationalisation Strategy - Health Board Estates Strategy - Health Board policies and procedures related to the maintenance of Health Board estate. 6 Facet survey completed in 2019. - Divisional Risk Register - Multiple policies and SOPs published and communicated to staff. - A robust internal training programme in place covering all aspects of estate management including food hygiene. - Improved statutory compliance processes and forum led by Designated Person - DP (Divisional Director) - Asbestos reinspection programme (over the next 3 years) - Additional capital allocation to Estates and Facilities for backlog maintenance reduction of £500k from discretionary allocation - HB-wide groups on compliance (such as Ventilation and water) are widened in membership to ensure clinical services are active participants - A clear approach to compliance monitoring and escalation of AE reports has been implemented.	- Active estate rationalisation (including leases) is required to reduce estate demands and help prioritise capital spend to reduce backlog maintenance. - A water/ventilation engineer to enable all critical ventilation systems to undergo annual validation in accordance with HTM 04/01. - Ongoing attempts to recruit to workforce gaps and a new model of Estate Officer also being developed to assist with recruitment and retention of staff in the workforce. - Planning function leading a review of capital priorities which may help identify additional funding priority given to backlog maintenance. - Policies being reviewed and priority given to out-of-date policies, but all policies will be reviewed for effectiveness and compliance with HTM. - Drive clinical service engagement in compliance meetings where engagement is low. - Additional escalation for capital funding by the Division Estates and Facilities to support the prevention of seasonal issues and plant failure if possible.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		
- Divisional reporting of Statutory and Mandatory training of staff - Staff training levels are monitored and reported regularly. If areas of non-compliance are noted, targeted training can be resourced to ensure compliance. - Outcome of the Asbestos reinspection programme	If the revised approach for monitoring and escalation of AE reports is effective in reducing the level of a deterioration.	Performance reporting
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>		
- The divisional risk register is reviewed quarterly by the Senior Management Board this is reported to the Quality & Patient Safety Operational Group - Regular reporting on estate condition to the Executive Committee and Partnerships, Health Protection & Planning Committee		
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>		
Internal Audit Reviews 2023- 24 Estates Assurance - Estate Condition. Audit completed and been shared with Audit Committee and Finance and Performance Committee Internal Audit Plan 2024-25 Estates Assurance – Energy Management (Q2) Outcome = Reasonable Assurance. Reported to the November ARAC. - Authorising Engineer (Shared Service Estates) reports in line with normal timelines, but active engagement with AEs through compliance processes. - Health Board contributes to annual Estates Facilities and Performance Managements (EFPMS) at all Wales level		
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>		
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively. Reasonable Assurance

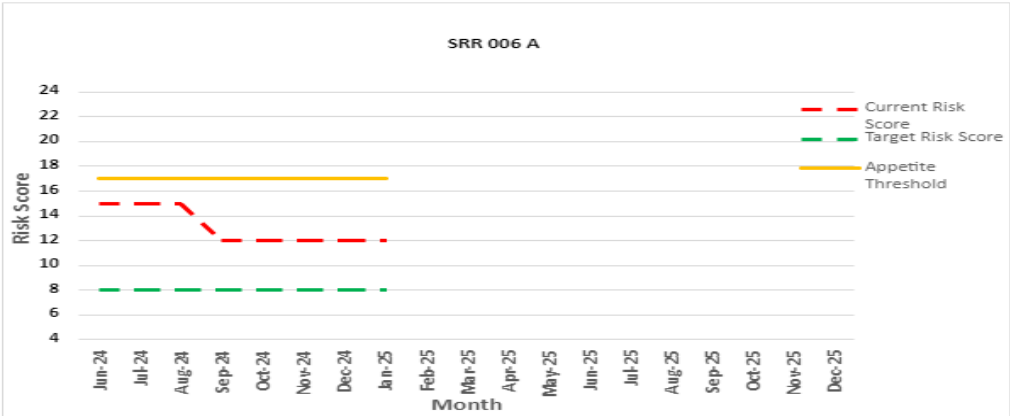
RISK THEME	COMPLIANCE AND SAFETY			
SRR 004	There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to a business continuity incident or critical incident.			Publication Status Public
Strategic Threat	A. Due to emergency planning arrangements at both the corporate and operational level not being sufficiently robust to respond to a Major Incident			Risk Appetite Level – MINIMAL Ultra-safe leading to only minimum risk exposure as far as practicably possible; a negligible/ low likelihood of occurrence of the risk after application controls.
Impact	- Adverse impacts on delivery of care to patients across acute and non-acute settings - Inability to respond to a major incident to meet needs of those affected - Harm or injury to patients and/or staff; - Health Board breaches statutory duties under the Civil Contingencies Act 2004; - Litigation & Financial Penalties; - Reputational damage and loss of public confidence			Risk Appetite Threshold – SCORE 8 AND BELOW. Risks relating to all aspects of patient safety but also including safeguarding, staff and public security in addition risks relating to compliance and/or legal implications.
				SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
				Expected Date Target Score will be Achieved –
				
Lead Director	Director of Strategy, Planning and Partnerships	Risk Exposure	Current Level	Target Level
Monitoring Committee	Partnerships, Public Health & Planning Committee	Likelihood	2 (Unlikely) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	3 (Moderate)
Last Reviewed	01 November 2024	Risk rating	= 8 (Moderate)	= 6 (Moderate)
Next Review (Six Monthly based on risk score)	01 May 2025			

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
Major Incident Plan and procedures - Local/Divisional action cards are in place. - Training undertaken service-specific relating to local response. - Major incident exercise ‘Euclid’ undertaken 20 June 24. Approx. 100 participants and external observers, demonstrated that the Health Board was able to successfully respond to an incident - As a result of the exercise action cards refreshed and renewed with teams to incorporate learning - Internal strategic on call training - Executive Team attending 2-day strategic training. - Loggist training is provided and accessed regularly - New all Wales log books are in place for use - Regular liaison with Gwent Local Resilience Forum (Strategic and tactical) - Joint Planning and Training with LRF and across Wales. - Ongoing Participation in exercises UK, Wales, LRF and HB. - Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP) - Continuing to work with the communication team to improve incident cascade during an event to ensure Health Board wide awareness in a timely manner	- Continue to deliver training programmes to support staff preparedness to response to an incident. - Additional ‘local’ team and intra team exercises to take place for areas to practice and embed their response to a major incident together - Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Coordination) structure of strategic, tactical, and Operational.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
Departmental debrief following an incident to inform learning and enhance controls. • Training records • Plans and action cards in place and up to date • Debrief with key stakeholders following an incident to inform learning and enhance controls.			
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
Report to the EPRR Group from debrief of incidents • Reports to the PPHP Committee on Emergency Planning Preparedness		•	
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
nternal Audit Review(s) • Business Continuity Planning 2023-24 (Q2) outcome report published – included MI response – Reasonable Assurance • Outcome and feedback from national exercises		Internal Audit Reviews 2023 – 24 • Savings Programmes – Reported to ARAC - Reasonable Assurance • Financial Controls – Reported to ARAC July 2024 – Substantial Assurance • Asset Management Q3 – Reported to ARAC April 2024 - Reasonable Assurance External Audit Reports 2023 -24 • Efficiency Review 23/24 Q3/Q4 – Not yet reported. • Structured Assessment - Received at ARAC November 2023. • Audit of Financial Statements Q4 2023/24 – True & Fair view given, minor recommendations, qualified on deficit and 3-year IMTP not agreed. • Financial assessment and review reports to Welsh Government – monthly • Enhanced monitoring T.I. meetings with Welsh Government – monthly	•
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>			
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable Assurance

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		
- Departmental debrief following an incident to inform learning and enhance controls. - Training records - Plans and action cards in place and up to date - Debrief with key stakeholders following an incident to inform learning and enhance controls.		
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>		
- Report to the EPRR Group from debrief of incidents - Reports to the PPHP Committee on Emergency Planning Preparedness		
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>		
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Assurance Rating <i>(Overall Assessment of controls and assurances)</i>		
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Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		
- The Escalation Framework has been enacted and is effective in mitigating threats and impact to services. - Performance report against measures/metrics	- Evidence that the Escalation Framework is delivering improvements across all areas of patient flow e.g., ambulance handovers. Now working to KPI WG plan. - The impact of the Performance and Accountability framework in improving patient flow	Close monitoring and reporting of the frameworks in practice to support learning and improvements.
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>		
- Divisional Assurance reviews. - Performance against measures/metrics reported to the Executive Committee		Operational framework coming into place in November / December 2024 and will be tested as part of a deep dive exercise.
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>		
Internal Audit Reviews - Intra-site Patient Transfers – Reasonable Assurance accepted by the ARAC on 9th July 2024. - External inspections/visits.		
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>		
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.
Reasonable Assurance		

RISK THEME	SERVICE DELIVERY			
SRR 006	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.		Publication Status	Public
Strategic Threat	a. Due to the full or partial failure of existing digital infrastructure and systems.		Risk Appetite Level - OPEN Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	- Harm or injury to patients and/or staff - Adverse impacts on delivery of care to patients across acute and non-acute settings - Data breaches - Litigation & Financial Penalties - Reputational damage and loss of public confidence		Risk Appetite Threshold - Score 17 and below Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.	
			SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
			Expected Date Target Score will be Achieved –	
				
Lead Director	Director of Digital	Risk Exposure	Current Level	Target Level
Monitoring Committee	Finance & Performance Committee	Likelihood	3 (Possible) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	4 (Major)
Last Reviewed	01 December 2024	Risk rating	= 12 (High)	= 8 (Moderate)
Next Review (Quarterly based on risk score)	01 March 2025			

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- Remedial Action Plan revised and updated to capture further recommendations against NIS CAF assessment in Jan 2024. This Action Plan has also supported ABUHB risk remediation responses to ABUHB's NIS CAF Risk Register which by CRU to address risks identified during the NIS CAF assessment. The remedial actions proposed have been accepted by CRU and progress will be reviewed annually. - Director of Digital (SIRO) and Chief Information Officer (Deputy SIRO) SIRO trained. - New Information Governance and Cyber Security governance and assurance processes reviewed and implemented. - Governance group terms of reference agreed. Meetings started in November 2023. - Cyber is fully engaged with IG colleagues to implement the recommendations of the Templar report. Cyber now supports all the Governance and Assurance Groups intending to increase cyber security awareness and build cyberculture amongst non-ICT staff - Scheduled monthly vulnerability scans of all ABUHB-managed servers to include third-party servers. The results of these scans will now be reported in the Monthly Cyber Report. - Working with Business Systems and Desktop Teams to ensure that patching compliance for internally managed systems and third-party systems is monitored and reported monthly. Monthly review meetings are held between Cyber, and the Teams review compliance levels against policy. Results are captured within the monthly Cyber Report. - Implement the recommendations from Templar report: - Work with Information Governance around implementing the controls required to achieve ISO27001 accreditation. - Battle tested OUR cyber incident response, communication cascade and reporting to Cyber Resilience Unit. This will be incorporated into the overall action plan. - Working with ICT Support Teams and the Log4j version 2 vulnerability has been resolved within the Health Board. The least important service impacting Version 1 is being managed through ICT Departmental risk management process. · Risk impact reduced as recent loss of power at key sites, incorporating our data Centre allowed is to failover in a seamless fashion from one DC to the other with no service impact. · - Maintained the use of Trust ware for all emails Trustwave provides inspection and protection from malicious links embedded within emails. · - Begun the roll out simulated phishing campaigns. The initial phishing has been tested on the ICT Department and reported within the Cyber Report. Cyber will continue campaigns during 2023 to increase email security awareness among staff. ·	- Implement the recommendations from Templar report: - Work with Information Governance around implementing the controls required to achieve ISO27001 accreditation. - A recent cyber incident at several London Hospitals presented an opportunity for ABUHB to battle test its cyber response, communication cascade and reporting to Cyber Resilience Unit. This will be incorporated into the overall action plan.

Introduced scenario-based incident response exercising using National Cyber Security Centre developed ‘Exercise in a box’ the aim is to assess our current skills in responding to real-life cyber security incident scenarios and to identify improvements. Cyber plans to run several more exercises during 2023.	

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		
Internal directorate meetings setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans.	Oversight from NHS Wales Cyber Resilience Unit.	An assessment against CAF was undertaken by CRU in January ‘24 and the report along with its recommendations has been circulated to key stakeholders.
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>		
Regular reporting on progress to the Finance & Performance Committee on the cyber security action plan.		
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>		
Cyber security Audit in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems.	Latest local survey saw a reduction in staff wellbeing	
Internal Audit 2024/25 Technical Continuity – planned for Q3		
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>		
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.
Reasonable Assurance		

RISK THEME	SERVICE DELIVERY					
SRR 006	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.				Publication Status	Public
Strategic Threat	b. Due to an adverse impact on service delivery in the implementation of the new digital systems.				Risk Appetite Level - OPEN Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	- Harm or injury to patients and/or staff - Adverse impacts on delivery of care to patients across acute and non-acute settings - Data breaches - Litigation & Financial Penalties - Reputational damage and loss of public confidence				Risk Appetite Threshold - Score 17 and below Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.	
					SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold	
					Expected Date Target Score will be Achieved –	
					SRR 006 B	

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- Adoption of formal project management methodologies PRINCE 2 to ensure project plans are developed in conjunction with services. - Formal governance arrangements in place through project boards and programme boards where risks and issues are managed and mitigated. - Each project has a senior responsible officer from the service who can provide challenge and assurance over the delivery of the project work packages. - Each clinical project has a clinical lead who would advise and support potential impacts on service delivery caused by the implementation of new digital services. - Business change team in place to support services in improvement of clinical and administrative processes. - Benefits team in place who identify, track, and ensure any benefits are realised which will ultimately improve service delivery. - Projects support backfilling of clinical time where required. - Assurance activities included in project framework including clinical safety, information governance, health records and cyber security. - An overarching Digital Portfolio Progress Group is in place to receive programme updates, manage risk and issue escalations and provide multi-disciplinary assurance over digital projects. - Business change work includes a service readiness impact assessment to enable the project team to develop a realistic plan that incorporates service change requirements. - Aggregated view of risks and issues available to pick up common themes and impact for early intervention or escalation. - Aggregated view of digital Lessons Learned available and lessons are reviewed during project initiation for best chance of success. - Information Governance Sub Committee and Cyber Security Subgroup established - Formal divisional engagement meetings in place monthly to discuss new programmes of work and provide update on critical programmes/projects	Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee

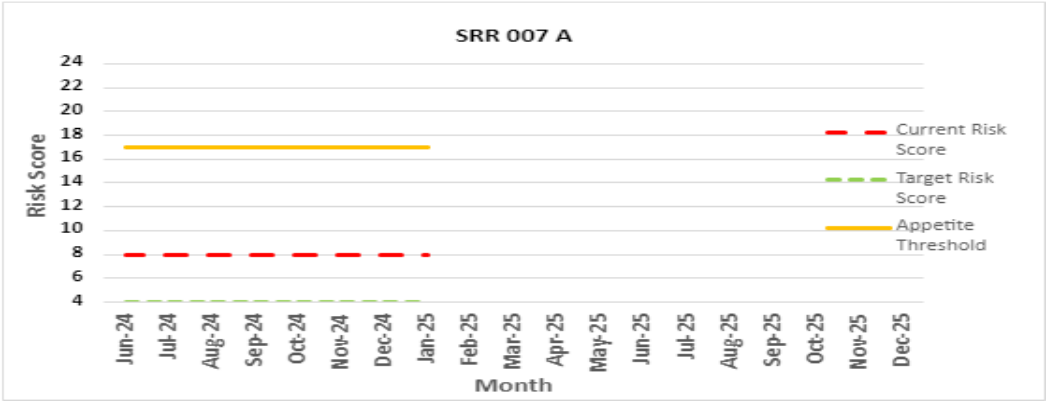
Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- Project Boards meet monthly and report into the bi-monthly Digital Portfolio Progress Group (DPPG) - Digital Directorate meetings being held monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. - Risk management approach and escalation processes in place in line with the Health Board’s Risk Framework		Escalation of risks and issues done on an Ad hoc basis to Director of Digital and Executive Committee in the absence of DDaT Sub-committee	Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
Regular Reporting to the Finance & Performance Committee			
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
- Cyber security Audit in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. Internal Audit 2023/24 - Benefits Management review – Outcome Substantial Assurance - Stakeholder Engagement on IT Projects 2023/24 Q3 – Outcome Substantial Assurance Internal Audit 2024/25 - Implementation of the Welsh Intensive Care System – planned for Q1			
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>			
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable Assurance

RISK THEME	SERVICE DELIVERY																																																																																
SRR 006	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.				Publication Status	Public																																																																											
Strategic Threat	c. Due to failure to develop digital solutions that are sustainable and fit for the future.				Risk Appetite Level – OPEN Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.																																																																												
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					SRR 006 C <table border="1"><caption>SRR 006 C Data</caption><thead><tr><th>Month</th><th>Current Risk Score</th><th>Target Risk Score</th><th>Appetite Threshold</th></tr></thead><tbody><tr><td>Jun-24</td><td>12</td><td>8</td><td>17</td></tr><tr><td>Jul-24</td><td>12</td><td>8</td><td>17</td></tr><tr><td>Aug-24</td><td>12</td><td>8</td><td>17</td></tr><tr><td>Sep-24</td><td>12</td><td>8</td><td>17</td></tr><tr><td>Oct-24</td><td>12</td><td>8</td><td>17</td></tr><tr><td>Nov-24</td><td>12</td><td>8</td><td>17</td></tr><tr><td>Dec-24</td><td>12</td><td>8</td><td>17</td></tr><tr><td>Jan-25</td><td>12</td><td>8</td><td>17</td></tr><tr><td>Feb-25</td><td>12</td><td>8</td><td>17</td></tr><tr><td>Mar-25</td><td>12</td><td>8</td><td>17</td></tr><tr><td>Apr-25</td><td>12</td><td>8</td><td>17</td></tr><tr><td>May-25</td><td>12</td><td>8</td><td>17</td></tr><tr><td>Jun-25</td><td>12</td><td>8</td><td>17</td></tr><tr><td>Jul-25</td><td>12</td><td>8</td><td>17</td></tr><tr><td>Aug-25</td><td>12</td><td>8</td><td>17</td></tr><tr><td>Sep-25</td><td>12</td><td>8</td><td>17</td></tr><tr><td>Oct-25</td><td>12</td><td>8</td><td>17</td></tr><tr><td>Nov-25</td><td>12</td><td>8</td><td>17</td></tr><tr><td>Dec-25</td><td>12</td><td>8</td><td>17</td></tr></tbody></table>		Month	Current Risk Score	Target Risk Score	Appetite Threshold	Jun-24	12	8	17	Jul-24	12	8	17	Aug-24	12	8	17	Sep-24	12	8	17	Oct-24	12	8	17	Nov-24	12	8	17	Dec-24	12	8	17	Jan-25	12	8	17	Feb-25	12	8	17	Mar-25	12	8	17	Apr-25	12	8	17	May-25	12	8	17	Jun-25	12	8	17	Jul-25	12	8	17	Aug-25	12	8	17	Sep-25	12	8	17	Oct-25	12	8	17	Nov-25	12	8
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Lead Director	Director of Digital	Risk Exposure	Current Level	Target Level																																																																													
Monitoring Committee	Finance & Performance Committee	Likelihood	3 <i>(Possible)</i> x	2 <i>(Unlikely)</i> x																																																																													
Initial Date of Assessment	01 June 2023	Impact	4 <i>(Major)</i>	4 <i>(Major)</i>																																																																													
Last Reviewed	01 November 2024	Risk rating	= 12 <i>(High)</i>	= 8 <i>(Moderate)</i>																																																																													
Next Review (Quarterly based on risk score)	01 February 2025																																																																																

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- New Digital Service Request process in place which provides governance in several key areas: - Automation of request process via ‘Seren’ the ICT Portal - Information Governance – ensuring new services have appropriate controls to keep patient information safe. - Cyber Security – ensuring new services adopted or developed meet the requirements of the cyber assessment framework. - Patient Safety – ensuring services do not introduce any patient safety risks. - Records – ensuring new systems comply with the requirements of records management. - Strong business analysis function in operation which ensures the “as-is” and “to-be” process mapping is undertaken which provides assurance that new services implemented are fit for purpose and delivery what stakeholders require. - Business change function which ensures implemented systems are effective and deliver the benefits required. - Formal framework in place for the adoption of new digital services and best practice guidance followed. - Annual planning processes include formal DDAT Annual Operational Plan aligned with service priorities identified in IMTP process - New Digital Request processes include fortnightly senior leadership scrutiny of requests, - New prioritisation framework & tool Monthly/quarterly Operational delivery aligned to ITIL standards - Annual operational plan completed and aligned with IMTP - Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities for Urgent Care, MH & LD, CSS, Division of Surgery & PCCS in place - Software Development uses an agile product management methodology using DevOps software for managing its backlog, delivery plan and sprints	- Monthly/quarterly Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities to be arranged for Division of Medicine, - Portfolio optimisation to ensure the resources of the service are aligned to key priorities - New Digital Request quarterly reporting to DDAT sub-committee - New governance structures to be put in place further to directorate restructuring - Development of product management approach to delivery of core software applications and extending use of agile processes to ICT

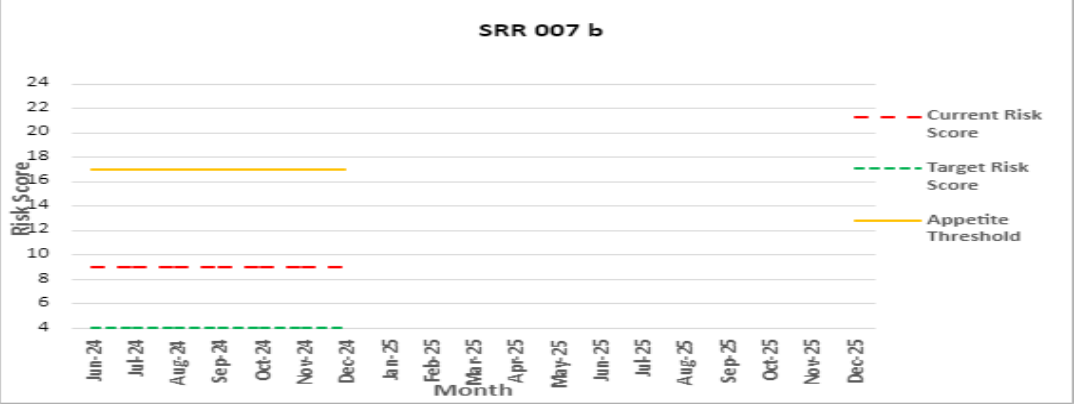
Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>		Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>	
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>					
Quarterly reporting to DDAT sub-committee		- If the NDSR process delivers anticipated improvements - The outcome of the EDRMS audit		- Monitor the performance of the NDSR process - Audit into the effectiveness and appropriateness of the electronic document and records management solution (EDRMS) in use for the management of digital health records and the provision of scanning services.	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>					
Regular Reporting to the Finance & Performance Committee					
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>					
- Cyber security in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. Internal Audit 2023/24 - LINC Programme– Outcome Reasonable assurance - Network Infrastructure (VPN) - Outcome Reasonable assurance Internal Audit 2024/25 - Electronic document and records management solution -planned for Q4					
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>					
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable Assurance		

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING			
SRR 007	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population.			Publication Status Public
Strategic Threat	A. Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.			Risk Appetite Level - OPEN Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.
Impact	- Unmet patient need resulting in harm - Ineffective use of combined resources - Delayed decision making - Adverse impacts on delivery of care to patients across acute and non-acute settings - Failure to deliver health board priorities, required improvements and achieve longer-term sustainability - Reputational damage and loss of public confidence			Risk Appetite Threshold - SCORE 17 AND BELOW All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change. SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold. Expected Date Target Score will be Achieved –
Lead Director	Director of Strategy, Planning, and Partnerships.	Risk Exposure	Current Level	Target Level
Monitoring Committee	Partnerships, Public Health & Planning Committee	Likelihood	2 (Unlikely) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	2 (Minor)
Last Reviewed	01 September 2024	Risk rating	= 8 (Moderate)	= 4 (Moderate)
Next Review (Six monthly based on risk score)	01 March 2025			



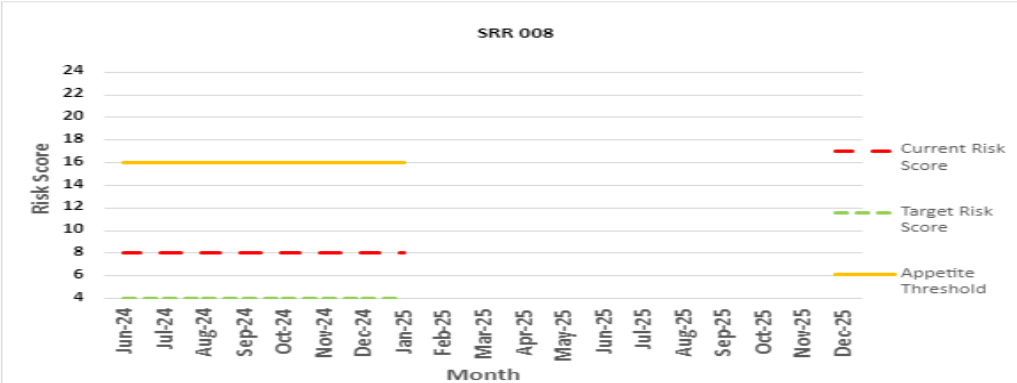
Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
The Health Board plays an active role in a range of formal partnership arrangements to enable integrated working for the population including: The Gwent Public Services Board (Gwent PSB) brings public bodies together to work to improve the economic, social, environmental, and cultural well-being in Gwent. They are responsible, under the Wellbeing of Future Generations (Wales) Act, for overseeing the development of the new Local Wellbeing Plan which is a long-term vision for the area. The Gwent Regional Partnership Board As set out in the Partnership Arrangements (Wales) Regulations 2015, local authorities and local health boards (RPB) manage and develop services to secure strategic planning and partnership working. RPBs also need to ensure effective services and care, and support is in place to best meet the needs of their respective population. Through these statutory forums formal partnership arrangements take place. In addition to these statutory forums the Health Board has a range of interfaces with key stakeholder bodies, including regular liaison with local authorities, neighbouring Health Boards, housing associations, and third-sector partners. Joint working between operational teams including integrated operational arrangements and combined multidisciplinary teams, for example, Community Resource Teams	- Governance review of Regional Partnership Board undertaken in August 2023. - Renewed Strategy for strategic partnership Capital in place and revised governance processes. - New Long-Term Strategy for Health Board to focus on Partnership approach.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>			Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>				
- PMO reporting to the Director of Strategy, Planning and Partnerships. - Regional Leadership Group Reporting			- Systematic reporting of outcomes - Systematic evaluation of schemes - Governance of financial control arrangements	- Implementation plan to be developed following RPB governance review. - Health Board strategy development approach to focus on partnership approach.
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>				
- Assurance reporting to the Population Health, Partnerships, and Planning Committee. - Assurance reporting to the Board.				
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>				
Internal Audit Plan 2024/25 - RPB Governance Review (Q4) – Outcome = Limited Assurance. Reported to ARAC September 2024 - Partnership Arrangements Review (Q1) Not yet undertaken				
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>				
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable Assurance	

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING			
SRR 007	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population.			Publication Status Public
Strategic Threat	B. Due to the impact of fragile services across the regional and supra regional geography			Risk Appetite Level - OPEN Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.
Impact	- Unmet patient need resulting in harm - Ineffective use of combined resources - Delayed decision making - Adverse impacts on delivery of care to patients across acute and non-acute settings - Failure to deliver health board priorities, required improvements and achieve longer-term sustainability - Reputational damage and loss of public confidence			Risk Appetite Threshold - SCORE 17 AND BELOW All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.
				SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
				Expected Date Target Score will be Achieved –
				
Lead Director	Director of Strategy Planning and Partnerships	Risk Exposure	Current Level	Target Level
Monitoring Committee	Partnerships, Public Health & Planning Committee	Likelihood	3 (Possible) x	2 (Unlikely) x
Initial Date of Assessment	04 January 2024	Impact	3 (Moderate)	2 (Minor)
Last Reviewed	01 December 2024	Risk rating	= 9 (High)	= 4 (Low)
Next Review (Quarterly based on risk score)	01 March 2025			

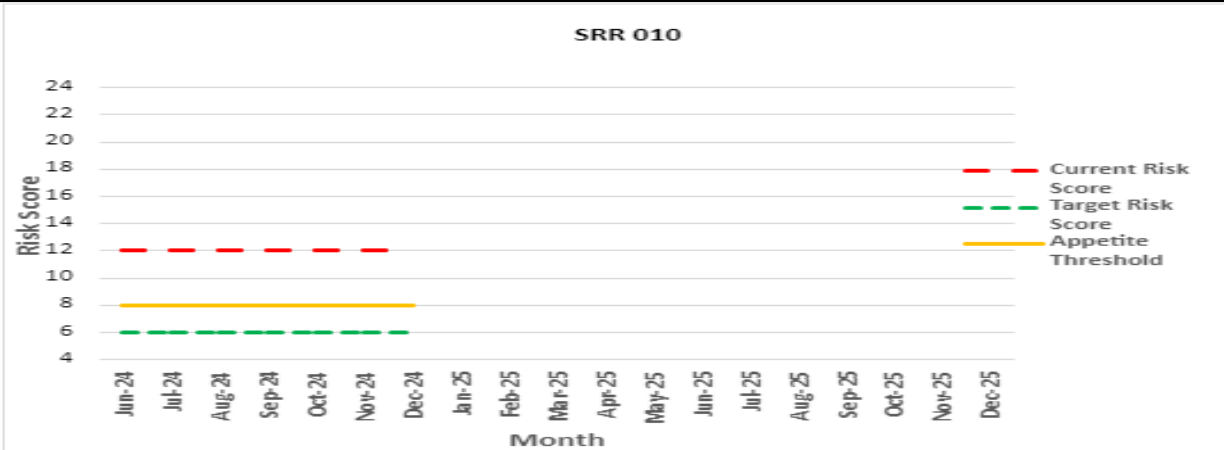
Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range?</i> <i>(Short, Medium, and Long-Term Plans need to be included)</i>
- A robust Southeast Wales regional planning infrastructure has been established with clear governance mechanisms in place with attendance from CEO, DoP and COO. - The Regional Portfolio Delivery Board brings the participating health boards together to review all regional service projects, to assess progress against agreed timelines and to agree additional measures / escalations in the event of identified issues and risks. This Board then reports to an Oversight Board with Chief Executive membership. - Four workstreams are established (Orthopaedics, Ophthalmology, Diagnostics and Cancer) and the UHB is well represented and engaged on all. - Where appropriate workstreams are underpinned by a Memorandum of Understanding between the participating health board, setting out their respective commitment to collaborative regional planning where this can enhance service sustainability, quality, and efficiency. - When service issues span regions, arrangements are set up on a bespoke basis, for example the Vascular Project Board and the Interventional Radiology (IR) project. In addition to these formal arrangements, the Health Board has a range of informal planning networks and communication channels, with an ongoing commitment to communication, sharing best practice and advising of anticipated service issues and risks.	The southeast Wales health boards have agreed revised joint priorities and working arrangements for regional planning in 2024, following a review workshop attended by Chief Executives. The revised priorities / forward work plan includes the following: - - An absolute commitment to delivering on the existing regional programmes of work but with these ‘re-baselined’ for 2024/25 to ensure there is a continued regional consensus on objectives, outcomes, and planning assumptions. - The need to review the current regional working governance arrangements, to ensure these remain fit for purpose. - The need to further review the indicative list of fragile services for the Southeast region and begin considering the regions response to these. - The need to develop a regional clinical service plan that can articulate what a long-term sustainable secondary care system looks like for Southeast Wales that can then inform local decisions (collaborative work has been undertaken in March with a parallel WG review of fragile services across south Wales, to ensure alignment of assumptions and priorities) - A further workshop (to include Chairs, Executives and clinicians) has been arranged for June Discussion ongoing at all Wales NHS CEOs and NHE Executive on governance and infrastructure to take forward cross regional planning to be reviewed considering IR and Neonatal work

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
• Service Divisions reporting to the Chief Operational Officer		• Alignment and effectiveness of partners to deliver integrated services	Internal Audit 2024/25 Recommendations from the Partnership Arrangements Review (Q1)
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- Assurance reporting to the Population Health, Partnerships, and Planning Committee. - Assurance reporting to the Board. - Regular touchpoint meetings of all key players to review progress and issues arising			
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
Internal Audit Plan 2024/25 Partnership Arrangements Review (Q1) - Not yet undertaken			
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>			
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable Assurance

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING			
SRR 008	There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.			Publication Status Public
Strategic Threat	A. Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement			Risk Appetite Level – Open Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.
Impact	- Unmet patient need resulting in harm - Ineffective use of combined resources - Delayed decision making - Adverse impacts on delivery of care to patients across acute and non-acute settings - Failure to deliver health board priorities, required improvements and achieve longer-term sustainability - Reputational damage and loss of public confidence			Risk Appetite Threshold – Open SCORE 17 AND BELOW All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.
				SUMMARY The current risk level is OUTSIDE of target but WITHIN the appetite threshold. Target level is WITHIN the set appetite threshold.
				Expected Date Target Score will be Achieved –
				
Lead Director	Director of Nursing	Risk Exposure	Current Level	Target Level
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	Likelihood	2 (Unlikely) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	2 (Minor)
Last Reviewed	01 July 2024	Risk rating	= 8 (Moderate)	= 4 (Moderate)
Next Review (Six monthly based on risk score)	01 January 2025			

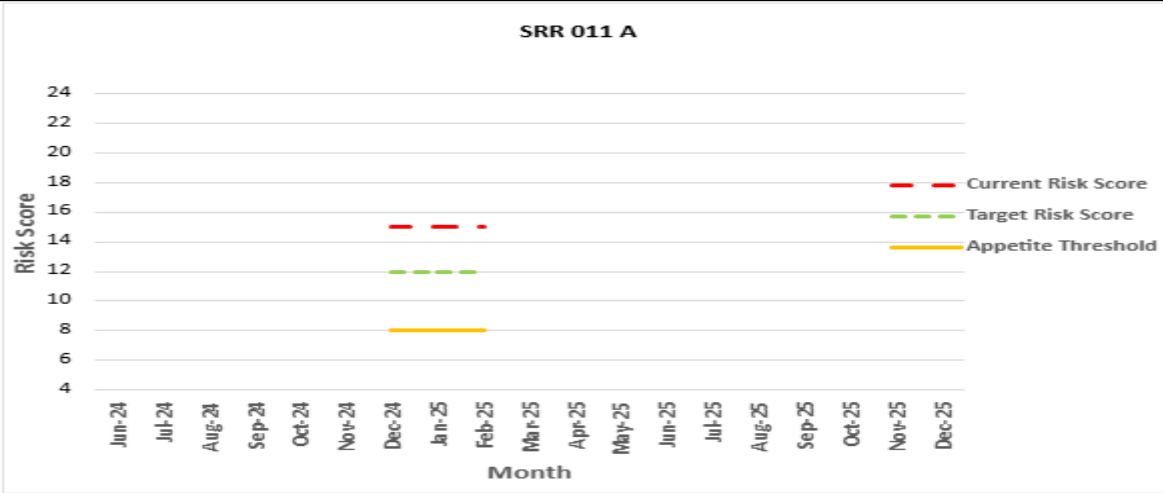
Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- Corporate Engagement Team - Patient Experience and Involvement Strategy- organisational ownership - Person Centred Care (PCC) Surveys via CIVICA - PCC KPI's (support PCC Quality pillar) 'You said..... we did' public facing information for service areas. - PLO service at GUH - Introduction of PALS Service (Oct 23) - Volunteer Patient Experience Feedback - Collaboration to recruit community listeners to support Dementia Awareness - Digital patient stories to support listening and learning. - Patient Experience and Involvement Strategy - DATIX - Oversight of Medical Examiner reports to determine patient experience actions - Public Engagement- Big Conversation Bereavement held 20th March 2024 - People Participation Panel ED in Progress	- Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress. - PCCT staff training to support Civica data entry and retrieval. - Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners. - Employment of dedicated PALS team who will have a key role in gaining feedback from patients, staff, and relatives. Monthly reporting in place and quarterly updates to QPSOG - Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data. No SMS provision. - Discussions with VBHC to pilot SMS in ED through DrDoctor - National directives around new national surveys that need to be managed additional to internal roll out programme. - Volunteer feedback to be reviewed to identify themes.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>			Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>				
- Patient Experience and Involvement Team oversee patient experience through dedicated work programme and link in with divisional teams. - Concerns are fed back to divisional teams when identified. - Outcome of the volunteer feedback to drive improvements. - Patient Experience and Involvement Team undertaking Culturally Competent Accreditation - Immediate feedback and escalation to clinical teams following PALS queries and concerns			- No SMS provision to increase the number of PCC surveys. - No single point of contact or ‘drop in’ provision for patients/families/staff to raise initial patient experience concerns. - Need to develop bereavement model and improve bereavement offer to meet Bereavement Standards. Resources being scoped. - Survey of bereaved people needs to be developed and rolled out to meet Bereavement Standards.	- Discussions with VBHC team to consider SMS through DrDoctor with pilot at ED - PALS Single point of contact is established. PALS officers have key role in patient experience and involvement- including establishing ‘drop in’ clinics on hospital sites should patients/staff/relatives wish to discuss concerns. Ned to have discussions with facilities around rooms. - Patient experience KPI’s and common themes need to be identified and reported through the PCC Survey. These will be added to a template patient experience report and CIVICA surveys will be built into ward accreditation.
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>				
- Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO) - Listening and Learning reported through QPSOG/ Outcomes Committee - Implemented PALS DATIX Module				
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>				
- LLais Reports - HIW inspections - Advocacy reports				
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>				
	Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable Assurance

RISK THEME	COMPLIANCE AND SAFETY			
SRR 010	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974			Publication Status Public
Strategic Threat	B. Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.			Risk Appetite Level - MINIMAL. Any risk that has a MINIMAL risk appetite level should be managed to a Score of 8 or below.
Impact	- Unintended physical harm; - Punitive actions from the Health and Safety Executive (HSE); - Increased levels of staff sickness; - Loss of estate due to unsafe environments; - Financial implications; - Adverse publicity; and, - Reputational damage			Risk Appetite Threshold - Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible / low likelihood of occurrence of the risk after application of controls.
				SUMMARY The current risk level is OUTSIDE of target level and OUTSIDE appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
				Expected Date Target Score will be Achieved –
				
Lead Director	Director of Allied Health Professions and Health Science	Risk Exposure	Current Level	Target Level
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	Likelihood	3 (Possible) x	2 (Unlikely) x
Initial Date of Assessment	01 December 2023	Impact	4 (Major)	3 (Moderate)
Last Reviewed	01 November 2024	Risk rating	= 12 (High)	= 6 (Moderate)
Next Review (Quarterly based on risk score)	01 February 2025			

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices. - Health and Safety Policies and Procedures - Dedicated Health and Safety site on ABPULSE - Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 ‘Health and Safety Assistance’. - Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) - Partial Programme of Health and Safety Monitoring (Active & Reactive) - Corporate and Directorate Health and Safety Risk Register established. - Board Training /development (Completed 24 April 2024) - Implementation of Health, Safety, and Fire Improvement Plan for 2023/24 to address 7 risk areas of concern. - Health and Safety Governance and reporting arrangements (Health and Safety Committee)	- Develop and implement a 3-year health and safety culture plan, including the implementation of a new Health and Safety Management System - Suitable and Sufficient Risk assessments (including local risk assessments, specific fire risk assessments, and fire risk assessments) - Consultation and communication with the workforce regarding compliance with the Act - New ways of working with Divisions to ensure accountability for health and safety is recognised. - Implement key performance indicators to monitor health and safety compliance. - Review the governance arrangements for the Health & Safety Committee - Health and Safety Policies and Procedures to be reviewed. - Onboard further Manual Handling trainers across the organisation to improve compliance. - Scope for training non-Health Board staff - Learning from events to be documented and communicated to the organisation.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>		Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>	
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>					
Health and Safety compliance data extracted from ESR and Datix and reported		- Implementation of a health and safety performance report - Health and Safety Committee Membership and governance to be reviewed to ensure there is robust scrutiny and challenge on compliance with the Act. - Compliance on completion of risk assessments and mitigating actions		- Revise accountability arrangements for Health and Safety being progressed as part of the organisational Health & Safety Governance Framework. - Review the membership and ToRs of the Health and Safety Committee - Risk assessments and mitigating actions to be documented and reported regularly to demonstrate progress against the Improvement Plan	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>					
- Established monitoring of H&S at the Executive Committee - Corporate H&S report risk and assurance to the Health and Safety Committee - Established monitoring of H&S at the PQSO Committee					
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>					
Internal Audit 2024/25 Plan - H&S processes - Performance reviews at All Wales Health and Safety Management Steering Group - South Wales Fire & Rescue Service fire safety audit programme. - Health and Safety Executive reviews/inspections.					
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>					
	Negative – Insufficient evidence that the controls in place are working effectively.		Reasonable - adequate evidence that the controls in place are working effectively.		Positive - robust evidence that the controls in place are working effectively.
Reasonable Assurance					

RISK THEME		SERVICE DELIVERY				
Strategic Risk SRR 011		There is a risk that the Health Board will not meet the carbon reduction target set by Welsh Government (16% reduction by 2025 and a 34% reduction by 2030) . This is common to all Health Bodies across the country.			Publication Status	Public
Strategic Threat (Due To)		➤ The effect of a failure to meet this target is on the wider environment due to the limitations to change estate and structural operations and available funds to implement strategic changes at scale to fully meet the target expected.			Risk Appetite Level – OPEN Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure	
Impact		➤ Failure to meet the target set on Welsh Health bodies for reducing carbon output ➤ Non–delivery of health board priority in this regard, required improvements, and achieving longer-term sustainability for the Health Board and nationally. ➤ Reputational damage and loss of public confidence ➤ Opportunity cost of reduced energy costs			Risk Appetite Threshold – SCORE 17 AND BELOW. Risk driven by the likelihood of the HB missing this target with some cause for optimism regarding making some progress towards reducing carbon emissions in some areas such as ReFit and changes in clinical practice. The impact locally is relatively small.	
					SUMMARY The current risk level is OUTSIDE of target level and WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
					Expected Date Target Score will be Achieved – Can Not Be Determined	
						
Lead Director	Director of Finance and Procurement	Risk Exposure	Current Level	Target Level		
Monitoring Committee	Finance and Performance Committee	Likelihood	5 (Almost certain) x	4 (Likely) X		
Initial Date of Assessment	30 October 2024	Impact	3 (Moderate)	3 (Moderate)		
Last Reviewed	01 February 2025	Risk rating	= 15 (Extreme)	= 12 (High)		
Next Review (Quarterly based on risk score)	01 March 2025					
Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)				Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)		

- Quarterly review of projects and workstreams at the Decarbonisation Programme Board - The project structure has 5 key workstreams each with a Health Board Lead covering clinical, communications, resources, waste and facilities and estates - Regular reporting of financial data available - Significant work already with the ReFit programme and Investment Grade Proposal (IGP) which aims to secure funding for projects of £7.4m, to reduce carbon emissions by 995 tonnes Co2 with a 10-year payback on investment. - Refreshed Decarbonisation Action Plans for 2024-25. The DAPs are integrated with other sustainability plans and were approved at the Decarbonisation Project Board in July 24. - Annual net zero return submitted to Welsh Government - Regular reporting of success stories in this area communicated across the Health Board (e.g., “Gloves R off”) - Decarbonisation Action Plans reported annually Executive lead and publicised on the green health website - SUS Qi training - Met office training - Carbon literacy training HEIW 4 modules on carbon reduction and net zero ESR - Spread & Scale academy training sessions	- Project structure regularly reviewed should action be needed. - Controls will be implemented further as part of the ReFit programme when it progresses following approval of the Investment Grade Proposal.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		
- Regular meetings of the sub groups to discuss position, monitor and new ideas - Bi-annual ISO14001 audit to be undertaken in October 2024. - Estates operational meetings	Detailed level metrics and measures are limited due to data capture equipment.	- All opportunities for funding will be optimised - Training opportunities will be maximised.
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>		
- Six monthly updates to the Board - Executive Committee (Clinical Futures Board) updates – Quarterly - Six monthly updates to the Finance & Performance Committee - Decarbonisation Programme Board – Quarterly reporting		- The annual reporting to Welsh Government via the net zero return is the main source of information for carbon output by the Health Board. However, it provides a relatively simplistic picture of output of total tonnes per carbon and so its value is limited. - Funding is the greatest limitation on achieving targets. All opportunities for funding will be optimised - Training opportunities will be maximised.
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>		
Internal Audit Report in July 24. - Received “limited assurance” but not because of controls – the issues were largely around funding limitations. External Audit Reports 2023 -24 - Periodic reports from Audit Wales – considered by the Audit and Risk Assurance committee	Funding for a comprehensive ABUHB decarbonisation strategy is not available.	As above - REFIT invest to Save capital opportunities being progressed.
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>		
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.
Reasonable Assurance		

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	18 February 2025
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Counter Fraud Annual Plan
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Robert Holcombe, Director of Finance, Procurement and Value Based Healthcare
SWYDDOG ADRODD: REPORTING OFFICER:	Gareth Lavington- Head CF

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

Ar Gyfer Penderfyniad/For Decision

To update the Audit Risk and Assurance Committee on the Counter Fraud Team's planned work for the 2025-26 financial year and seek approval for the proposed plan.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

ABUHB is legally bound to provide a Counter Fraud service. As a result, they employ a Counter Fraud team who maintain the aim of mitigating fraud to an absolute minimum. In so doing the team must comply with the NHS requirements of the Government Functional Standards S013 and the Welsh Government Directions.

One of the NHS requirements is that ABUHB completes a plan for the proposed Counter Fraud work. The head of Counter Fraud completes the plan and gains agreement from the Director of Finance, Procurement and Value.

Cefndir / Background

This document has been prepared by the Head of Counter Fraud to address the inherent and emerging Fraud Risks faced by the organisation, to plan for any required investigation work, and to prepare an educational and promotion strategy for the upcoming year.

Asesiad / Assessment

Please see separate report

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to approve the Counter Fraud work plan for 2025-26.

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

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

Gwybodaeth Ychwanegol:**Further Information:**

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

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

Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive

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



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	18 February 2025
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Counter Fraud Progress Report 2 – 2024/25
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Robert Holcombe, Director of Finance, Procurement and Value Based Healthcare
SWYDDOG ADRODD: REPORTING OFFICER:	Gareth Lavington Head of Counter Fraud

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

Er Gwybodaeth/For Information

To update the Audit, Risk and Assurance Committee (ARAC) of the work undertaken by the Counter Fraud Team in order to provide assurance that this work remains effective.

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

In order to remain compliant with the NHS requirements of the Government Functional Standards S013 the Counter Fraud Department are required to report the progress of their work to the ARAC

Cefndir / Background

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.

Asesiad / Assessment

1. Promotion / Education

Corporate Induction

Counter Fraud awareness at Corporate Induction remains a mandatory requirement. Subsequently all new starters have an immediate input into Counter Fraud when commencing employment with ABUHB. The statistics in relation to the amount of those who have taken part in Corporate Induction are not available at this time.

E Learning

In February 2024, the ESR Counter Fraud E-Learning module was mandated for ABUHB staff. During this financial year 5645 members of staff have completed the learning. When benchmarked against other NHS Organisations ABUHB can be seen to be performing well. (See table)

E-Learning Summary 2024-25							
VPD	HB	March 2015 - March 2024	Q1	Q2	Q3	24/25 YTD	March 15 - Dec 2024
001	CVUHB	1166	9	6	6	21	1187
020	WAST	6656	287	234	241	762	7418
025	DHCW	971	181	90	47	318	1289
028	PHW	521	11	21	7	39	560
040	ABUHB	8828	3576	935	1134	5645	14473
043	NWSSP	525	345	397	247	989	1514
050	BCU	23569	3840	2753	1766	8359	31928
070	Powys	91	2	0	0	2	93
082	HEIW	19	6	0	1	7	26
100	H DUHB	11944	1272	1188	1015	3475	15419
110	CTM	427	8	9	12	29	456
120	Velindre	894	1	0	0	1	895
130	SBUHB	2048	38	83	64	185	2233
TOTAL		57659	9576	5716	4540	19832	77491

Fraud Pop Ups/IFAW

The Team welcomed the opportunity to staff a number of 'Fraud Stalls' during International Fraud Awareness Week (Nov 17-24) across the organisational estate. These were held at NHH, RGH, GUH, YAB and YYF. A total number of 210 members of staff were engaged with during the course of the week. This has led directly to a number of referrals and requests for educational awareness sessions.

Fraud Awareness Presentations

Three presentations have been carried out in person engaging with over one hundred and 50 Staff members. (Audiology, Health Promotion)

Digital

In collaboration with the ABUHB Communications team 'How to report a Fraud' has now been added to the 'How to' drop down box on the main AB Pulse page. This makes it significantly easier to navigate to the fraud pages.

In addition, the digital offering that is hosted on the AB Pulse platform has been updated and modernised inclusive of the creation of interactive fraud contact forms. This work continues. The Fraud pages on the intranet can be found here:

[Fraud - Home](#)

2. Investigation

At the start of this reporting period there were **31** investigations open. A further **20** investigations have commenced during this period. Of these cases **32** have now been closed.

The investigation of these offences has resulted in **4** disciplinary sanctions (2 dismissals, 2 written warnings) and 6 civil recoveries.

3 members of staff have been interviewed under caution, and two case files have been prepared for submission to the Crown Prosecution Service. One of these has been returned with the result of no prosecution to take place. A review has been requested. A case conference with the Senior Prosecuting manager at the CPS is arranged for 28th January 2025.

At 31/12/2024 **19** cases were open and being actively investigated by the team.

A sanitised list of cases dealt with in this financial year is at **Appendix 1**.

Of Note during this period of reporting a number of referrals have been received that relate to the selling of weight loss drugs. (Ozempic). One case is being furthered and a formal interview with a community patient has been arranged. This relates to the onward selling of these drugs that were obtained on prescription at NHS cost. Subsequently the Counter Fraud team have commenced a proactive exercise involving the audit all community prescribing of this type of drug. The results of this will be reported in due course however early indications show that this is a wider problem and has involved erroneous over prescribing by GP practices. In order to avoid any further financial loss an educational bulletin has been shared with all Practice Managers in the ABUHB area; a request has been made for each practice to fully audit their prescribing of these drugs; and Counter Fraud have attended the regional meetings of Primary Care Contractors to support this information drive.

During this period civil recoveries made or that have commenced total **£84458.79**.

£81,646.82 of this is accounted for in salary overpayment recoveries;

And, **£2811.97** in relation to cases of fraud.

A fraud prevention figure of **£9876.00** has also been achieved. This related to an attempted invoice fraud at a primary care contractor. Due to the previous educational work delivered to this cohort by the Counter Fraud team this remained an attempt rather than a successful fraud.

NFI

December 2024 saw the release of the latest data from the National Fraud Initiative. Work has commenced in reviewing this data. There are 283 enquiries that are initially reported. This is expected to rise as further data sets are released. Work has commenced in respect of these. Investigations have commenced into the Payroll to Payroll matches data. To date have been cleared with no issues arising.

3. Prevention

Alerts and Bulletins

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

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

Local Proactive Exercises (LPE)

6 Local Proactive Exercises have been commenced as a direct result of local intelligence. They involve the following areas.

- Staff Leavers – Uniform, ID badges etc
- WP10 Hospital Prescription Security
- WP10 Community Prescription Security
- Staff Expense Claims
- Weight loss medication prescribing in the community
- Claiming of Out-of-Pocket Expenses community Pharmacy

The last of these is complete. A non-fraud prevention figure (saving against future losses) of **£21,600** has been achieved as a direct result of the disruption activity employed.

Priority is being given to the Weight Loss drug issue at this time as reported earlier.

Risk Assessment

A Fraud Risk Profile has now been designed and implemented to assist in managing the assessment of fraud risks to the organisation. It is intended that formal fraud risk assessment as a work stream will now be prioritised. An update in relation to this area of work will be provided to ARAC twice per year. A copy of this profile is provided in Appendix 2.

The inherent fraud risks identified by the NHS CFA and listed in this document will be allocated as resource allows.

Risk assessments into those areas identified for LPE above have been commenced.

4. Strategic Governance

A recruitment exercise took place during Q3 for a new LCFS. An experienced LCFS has been successfully appointed to the role, they commence on 3rd February. They join the team at 0.8WTE. An existing team member has, on January 5th reduced their hours from 1.0 WTE to 0.65 WTE. As a result, in total, the team resource will, upon February 3rd 2025 be equivalent to 3.4WTE. All staff are accredited experienced counter fraud specialists and investigators and this places ABUHB in a very strong position moving forward. In respect of 2025-26 financial year the Counter Fraud provision will be at its

highest ever level with 701 days planned for. The table below provides benchmarking figures in relation to resources across NHS Wales for 2024-25.

Health Body	LCFS Annual WTE	Admin Support Annual WTE	Annual Planned LCFS Days
Aneurin Bevan UHB (ABUHB)	3.00	0	630
Betsi Cadwaladr UHB (BCUHB)	2.91	0.5	590
Cardiff & Vale UHB (CVUHB) *	2.18	0	480
Cwm Taf Morgannwg UHB CTMUHB) **	2.60	0.2	606
Digital Health & Care Wales (DCHW) *	0.39	0	85
Health Education & Improvement Wales (HEIW) *	0.39	0	85
Hywel Dda UHB (H DUHB)	2.00	0	420
NHS Wales Shared Services Partnership (NWSSP)	1.00	0	210
Powys THB (PTHB) **	1.20	0.2	308
Public Health Wales (PHW) *	0.45	0	100
Swansea Bay UHB (SBUHB) **	3.20	0.6	704
Velindre NHS Trust (VUNHST) *	0.45	0	100
Welsh Ambulance Service Trust (WAST)	2.00	0	420

Argymhelliad / Recommendation

That the Audit, Risk and Assurance Committee take assurance from the information provided in this report that the Counter Fraud provision remains effective, compliant and focussed.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

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

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/	Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies Choose an item.

APPENDIX 1

Investigation Number	Investigation Subject	Date Opened	Date Closed	Outcome
WARO/19/00145	WLI Claims	19/12/2019 - CO	02/04/2024	Fraud NFA
INV/22/01184	Claiming payment for shifts not worked	26/08/2022 - CO	Awaits Internal outcome	Interviewed under Caution. Evidence gathered showed that a number of dates had not been worked. Returned to HR for disciplinary investigation as criminal investigation did not meet threshold for charging.
INV/22/01414	Salary overpayment	04/10/2022 - CO	Awaits internal outcome	Interviewed under caution. Admitted to knowingly receiving payments. Repaying the money and referred back to directorate for disciplinary.
INV/23/00258	Timesheet & travelling expenses fraud	06/02/2023 - CO	24/09/2024	22/08/24 Dismissed Gross Misconduct, GDC pending
INV/23/00920	Takin of unauthorised leave	23/04/2023 - CO	23/09/2024	Verbal Warning following fast track disciplinary
INV/23/00761	Working a clinic in Private Hospital whilst on breavement leave	24/04/2023 - CO	Awaits internal decision	Subject was interviewed under caution. Offences identified but did not meet the Public Interest threshold for prosecution. Referred back to directorate for consideration of UPSW procedure
INV/23/01521	Claiming payment for shifts not worked	28/07/2023 - CO	Awaits internal decision	Full investigation carried out and case file submitted to CPS. CPS declined to prosecute. The matter has been referred back to HR for consideration of disciplinary proceedings.
INV/23/01520	Failing to notify non payment of salary sacrifice	28/07/2023 - CO	Awaits repayment	Referred to Accounts Receivable for financial recovery
INV/23/01532	Salary Overpayment	31/07/2023 - CO	12/09/2024	Closed NFA Fraud
INV/23/01741	Salary Overpayment	18/08/2023 - CO	Awaits repayment	Pre Dashboard referral - subject retired and returned and there was confusion over pension payments. Not continued as fraud investigation. Awaits recovery
INV/23/02253	Leave fraud	10/10/2023 - CO	21/08/2024	21/08/2024 Dismissed Gross Misconduct
INV/23/02348	Breach of salary sacrifice contract	18/10/2023 - CO	17/04/2024	Disciplinary hearing completed - written warning issued in relation to nonfraud offences. No losses to fraud identified.
INV/23/02342	working whilst on sick	18/10/2023 - CO	Awaits decision re UPSW	CF investigation closed. No offences disclosed. No further action being taken internally. Matter closed
INV/23/02427	Salary Overpayment	27/10/2023 - CO	Awaits Repayment	Referred back to AR for financial recovery. No offences identified
INV/23/02531	Salary Overpayment	10/11/2023 - CO	30/04/2024	Closed NFA Fraud
INV/23/02837	working whilst on sick	12/12/2023 - CO	25/06/2024	Referred back to Accounts Receivable for recovery. Repayments commenced
INV/23/02860	Salary Overpayment	13/12/2023 - CO	08/05/2024	Closed NFA Fraud
INV/23/02928	Salary Overpayment	20/12/2023 - CO	01/05/2024	Closed, repaid in full
INV/24/00109	working whilst on sick	17/01/2024 - CO	07/06/2024	Managerial concerns only. NFA Counter Fraud

INV/24/00191	patient charge evasion	25/01/2024 - CO	01/10/2024	Investigation complete. Transferred for surgery Feb 24. No offences disclosed
INV/24/00204	additionally payments	26/01/2024 - CO	13/09/2024	Investigation complete. No offences disclosed. Referred back to Madical Directorate for a dceion re repayment or UPSW issues.
INV/24/00361	Pharmacy Fraud	14/02/2024 - CO	04/10/2024	NFA
INV/24/00480	working whilst on sick	27/02/2024 - CO	19/07/2024	Managerial concern issues only. NFA Fraud
INV/24/00491	secondary employment/timesheet fraud	28/02/2024 - CO	08/10/2024	Managerial Concern issues only - No offences disclosed
INV/24/00668	Anonymous letter alleging cronyism	15/03/2024 - CO	17/06/2024	Not substantiated. No further action
INV/24/00686	overpayment of supplementary allowance	18/03/2024 - CO	04/04/2024	NO issues re overpayment. Case closed
INV/24/00833	working whilst on sick	02/04/2024	16/04/2024	One occasion off sick with work related stress - continued with placement. Then left the organisation. Case closed NFA
INV/24/00857	Theft from omnicell	05/04/2024		Fully investigated and IUC carried. Full admission - Proportionate for disciplinary only -
INV/24/00945	working whilst on sick	16/04/2024		IUC carried out. Evidence that work carried out whilst sick. However most proportionate route via disciplinary
INV/24/00944	Leave fraud	16/04/2024		Managerial Issues only. Referred back for disciplinary
INV/23/02142	Declaration failure on NHS application form	18/04/2024	18/04/2024	Closed NFA Fraud
INV/24/00998	secondary employment during NHS contracted hours	19/04/2024	30/04/2024	Fraud NFA, Malicious reporting
INV/24/00993	false claiming for shifts	19/04/2024	03/07/2024	Fraud NFA, Malicious reporting
INV/24/01038	Self prescribing of medication with cost implications	23/04/2024	16/05/2024	Fraud NFA, repaid in full
INV/24/01050	Salary Overpayment	24/04/2024	06/06/2024	Fraud NFA, repaid in full
INV/24/01034	Allegations of cronyism	24/04/2024	07/06/2024	No offences disclosed
INV/24/01085	Falsified Medical records to further a negligence claim against HB	29/04/2024	30/09/2024	No Offences disclosed. No ongoing legal case involving persons named in intelligence
INV/24/01180	Career break - received full pay	08/05/2024	21/08/2024	Closed NFA Fraud
INV/24/01186	Salary overpayment	09/05/2024	16/05/2024	Closed NFA Fraud
INV/24/01202	Paid in error - no fraud	13/05/2024	21/05/2024	Closed NFA Fraud
INV/24/01205	Salary overpayment	13/05/2024		Enqs Carried out. No offences disclosed - returned to AR for financial recovery
INV/24/01204	Salary Overpayment	13/05/2024	20/09/2024	Closed NFA Fraud - Financial recovery only
INV/24/01199	Salary Overpayment	13/05/2024		Enqs Carried out. No offences disclosed - returned to AR for financial recovery
INV/24/01221	Bank shift allocation	14/05/2024	16/05/2024	Closed NFA Fraud
INV/24/01241	Salary overpayment /£12,032.82 - £8,964.84	15/05/2024	29/11/2024	Enqs Carried out. No offences disclosed - returned to AR for financial recovery

INV/24/01255	False sickness allegation via intel	17/05/2024	04/06/2024	Closed NFA Fraud
INV/24/01290	Mass Vacc recruitment	21/05/2024		Negotiated reduced payment tba
INV/24/01310	Late termination	22/05/2024	29/11/2024	Closed NFA Fraud
INV/24/01318	Completion of course while on sick leave	23/05/2024	09/09/2024	Closed NFA Fraud
INV/24/01487	Theft of Medication from Hospital Ward	11/06/2024	14/05/2024	Closed NFA Fraud
INV/24/01508	Salary overpayment	14/06/2024	01/07/2024	Closed NFA Fraud
INV/24/01663	Anonymous allegation - theft of cleaning items GUH	01/07/2024	19/09/2024	Closed NFA Fraud
INV/24/01667	False sickness allegation via intel	01/07/2024	01/07/2024	Closed NFA Fraud
INV/24/01886	Theft and Misuse of WP10 HPs	24/07/2024		Ongoing Case
INV/24/01887	Allegation - working privately at Spire in NHS time	24/07/2024	12/09/2024	Closed NFA Fraud
INV/24/01935	Owner of Cutting Edge Fitness	31/07/2024	10/01/2025	No evidence that Subject working on sick. Other managerial issues ongoing.
INV/24/01993	Allegedly selling prescription meds	08/08/2024	19/09/2024	Closed - Intelligence shared with Gwent Police
INV/24/01230	Fraudulent invoice attempt	28/08/2024	19/09/2024	Attempt payment diversion fraud. Prevented
INV/24/02433	Not workingfull hours but claiming payment	30/09/2024	07/10/2024	No Offences identified - No further action required CF

Appendix 2

Fraud Risk Profile – Separate Document



Counter Fraud Work Plan 2025/26

Gareth Lavington
Head of Counter Fraud

22/01/2025

COUNTER FRAUD WORK PLAN 2025/2026

Introduction

The Aneurin Bevan UHB Counter Fraud Team consists of the Head of Counter Fraud and three Local Counter Fraud Specialists (LCFS). One LCFS is full time and two are part-time (0.6 & 0.8 WTE respectively). All are accredited, experienced investigators, whose role is to operationally meet the organisation's obligations for countering fraud, bribery, and corruption. There is an improvement in resource on the previous year allowing an additional 71 days taking the provision to a total of 701 days for the year ahead. This has been achieved as a result of the successful recruitment of a further LCFS (Feb 2025) on a part-time basis following a review of skill mix and remaining within the existing departmental budget.

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. The Director of Finance, Procurement and Value Based Health Care retains ultimate responsibility for Counter Fraud work as the accountable member of the board.

The introduction of new Government Functional Standards on Counter Fraud in 2021, replaced the long-standing NHS Counter Fraud Authority's (NHS CFA) 'NHS Counter Fraud Standards (Wales)'. The ABUHB Counter Fraud Workplan aims to ensure compliance with these new standards.

This Workplan incorporates proactive activity (Inform & Involve, Prevent & Deter and Strategic Governance) as well as reactive activity (Investigation/Hold to Account.) The Workplan provides for **365 proactive** days – and **336 reactive** days. (Due to the nature of Counter Fraud work this remains flexible).

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

The allocation of Proactive days in this workplan exceeds this expectation (436 Days)

COUNTER FRAUD WORK PLAN 2025/2026

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 by the Head of Counter Fraud on an annual basis using a R(ed)A(mber)G(reen) rating system. This is subject to compliance testing by the NHS CFA.

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 2025/2026

INFORM AND INVOLVE		
	TASK/OBJECTIVE	PROPOSED DELIVERY
1	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.	Throughout the Year
2	Undertake promotional work to highlight the availability of counter fraud awareness training aiming to increase attendance numbers, foster relationships throughout the organisation in order to improve awareness of the team.	Throughout the Year
3	Attend relevant Primary Care Forums in order to provide regular updates to Primary Care partners concerning emerging trends	Throughout the Year
4	Identify emerging trends/risks and provide bespoke educational awareness to staff affected.	As Appropriate
5	Actively promote and encourage staff awareness and completion of the mandatory Counter Fraud E-learning package.	Throughout the Year
6	Arrange for pay-slip messaging to be utilised during the year as appropriate.	As Appropriate
7	Develop a digital Counter Fraud newsletter that can be incorporated into the general communication briefings that are currently being circulated amongst staff via the AB Pulse platform.	Quarterly
8	Carry out a review of the strategy employed for raising awareness of fraud risks and the counter fraud team. Liaise with relevant communications staff to identify further opportunities that can be exploited. E.g. regular Webinar events that staff can digitally drop into.	Q1

COUNTER FRAUD WORK PLAN 2025/2026

INFORM AND INVOLVE		
	TASK/OBJECTIVE	PROPOSED DELIVERY
9	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.	Q4
10	Develop and publish monthly Counter Fraud topic bulletins to staff across the organisation using AB Pulse platform.	Monthly
TOTAL DAYS ALLOCATED		163

COUNTER FRAUD WORK PLAN 2025/2026

PREVENT AND DETER		
	TASK/OBJECTIVE	PROPOSED DELIVERY
11	Review key organisational policies, procedures, and documents, to ensure that fraud risk is adequately considered. Attend Policy Group Meetings and review agenda items in order to achieve this.	Monthly
12	Design and implement a local risk profile identifying inherent and emerging specific fraud risks. Carry out risk analysis in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology. Carry out formal risk assessment into all inherent and emerging areas of fraud risk as identified locally, nationally or by the NHS CFA.	Q1 Throughout the Year
13	Record identified fraud risks on risk registers (DATIX) in order to ensure the effective management of them by risk owners. Work closely with risk owners in order to identify remedial measures that can effectively be undertaken to reduce the opportunity for fraud to occur, and, if required take measures to achieve system/process/policy change in line with GovS 013 component 2, GovS 013 component 3 and GovS 013 component 5.	Throughout the Year
14	Liaise with Corporate Governance colleagues in measuring the effectiveness of the 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
15	Engage in regular meetings with the Head of Internal Audit (NWSSP Audit & Assurance)	Quarterly
16	Action relevant Fraud Prevention Notices and IBURN issued by NHS Counter Fraud Authority and/or Counter Fraud Services Wales as and where appropriate.	As Appropriate
17	Issue of fraud alerts/notices to all appropriate staff/contractors.	As Appropriate

COUNTER FRAUD WORK PLAN 2025/2026

PREVENT AND DETER		
	TASK/OBJECTIVE	PROPOSED DELIVERY
18	Ensure 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
19	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).	As appropriate
21	Participate in thematic fraud risk evaluation exercises as instructed by the NHS Counter Fraud Authority.	As appropriate
22	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 CLUE, 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 achieved as a result of disruption activity are to be identified and recorded.	Throughout the Year
23	Membership of Controlled Drugs Local Intelligence Network (CD LIN) and attendance at quarterly meetings to be maintained. (This is an intelligence sharing exercise involving Primary Care Pharmacy teams, Police and Counter Fraud.)	Quarterly
TOTAL DAYS ALLOCATED		163

COUNTER FRAUD WORK PLAN 2025/2026

HOLD TO ACCOUNT		
	TASK/OBJECTIVE	PROPOSED DELIVERY
24	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
25	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
26	Assist NHS Counter Fraud Authority and/or NHS CFS Wales as required in respect of any regional or national investigations.	Reactive/As Required
27	Ensure the application of sanctions in line with legislation and the policy document 'Applying Appropriate Sanctions Consistently'.	Reactive/As Required
28	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
29	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
30	Conduct initial review of the matches identified on the National Fraud Initiative (NFI) Where required instigate formal investigation into matches that require it.	Q1/Q2/Q3
TOTAL DAYS ALLOCATED		265

COUNTER FRAUD WORK PLAN 2025/2026

STRATEGIC GOVERNANCE		
	TASK/OBJECTIVE	PROPOSED DELIVERY
31	Attend all Fraud Forum meetings held by NHS CFS Wales.	Q1/Q3
32	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 be nominated to the NHS CFA in March. This will be the new Assistant Finance Director – Financial Services).	Q1
33	Completion and agreement of the annual work plan 2026/27 with Director of Finance in line with GovS 013 component 2.	Q4
34	Completion of the annual report (2025-2026) for review by Director of Finance and Audit Committee.	Q1
35	Regular meetings/liaison with Director Of Finance (2 monthly or as required) Assistant Director of Finance – (Weekly).	Throughout the Year
36	Preparation for and attendance at ARAC meetings.	As Required
37	Full participation in the quality assurance process as directed by NHS CFA.	Q4 and As Required
38	Undertake additional training as required by the Health Board or NHS CFA.	As Required
39	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
40	Provide regular reports and <i>ad hoc</i> information to NHS CFA and Welsh Government as required	Throughout the Year
41	Ensure representation at the Counter Fraud Steering Group	Quarterly
42	Ensure attendance at all Lead LCFS meetings to share best practice and emerging trends	Quarterly

COUNTER FRAUD WORK PLAN 2025/2026

STRATEGIC GOVERNANCE		
	TASK/OBJECTIVE	PROPOSED DELIVERY
43	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.
	TOTAL DAYS ALLOCATED	110

SUMMARY TOTALS

	STRATEGIC AREA OF ACTIVITY	RESOURCE Proposed 2024/25 (days)	RESOURCE Proposed 2025/26 (days)
A	INFORM AND INVOLVE	176	163
B	PREVENT AND DETER	80	163
C	HOLD TO ACCOUNT	265	265
D	STRATEGIC GOVERNANCE	109	110
	TOTAL	630	701

COUNTER FRAUD WORK PLAN 2025/2026

NB. In order to prioritise the work of 'prevent and deter' the proposed days provision has significantly increased. Likewise, the provision for 'Inform and Involve' has seen a slight reduction in days to compensate. This will allow for a more balanced service moving forward.

Risk area	Risk Owner	Risk in Brief	Counter Fraud Risk Score	RA Completed	Recorded on CLUE	Recorded on Datix	Recorded on Risk Register	Review Date	Recomedations Made Y/N	Risk Assessment Document	Notes	Assigned To
EMPLOYEE CLAIMS												
NHS employees / Leave		A NHS employee (the actor), fabricates records and or falsifies authorisation (the action) to obtain more leave than they are entitled to (the outcome)										
NHS employees / Timesheet/overtime		A NHS employee (the actor), inputs incorrect falsified details onto a timesheet or falsifies a signature (the action) for personal gain (the outcome)										
NHS employees / Travel/ subsistence		A NHS employee (the actor), dishonestly claims for travel, subsistence or other expenses claim they are not entitled to (the action) for personal gain (the outcome)										NT
Staff - Sickness Fraud	WOD/Health Board	Working elsewhere - This relates to somebody reporting as sick with the NHS and completing work with secondary employment whilst claiming sick pay										
Staff - Sickness Fraud	WOD/Health Board	False sickness - This type of fraud can occur when a member of staff reports as being sick to the organisation when they in fact fit for work.										
PAYROLL												
Overpayment of Salary		This is where an employee receives payment of salary when not entitled to those payments. This could be when the employee has left employment and continues to be paid or who has inflated pay and continues to receive the inflated rate.										
DECLARATIONS OF INTEREST/GIFT/ETC												
Employees - Staff collusion / Bribery		An Individual (the actor), offers or receives and inducement, gift or hospitality (Bribery), (the action), to dishonestly influence the action(s) of another (the outcome)										
NHS employees / Working elsewhere		A NHS employee (the actor), works elsewhere whilst employed and being paid for by the NHS during NHS time (the action) for personal gain (the outcome)										
CLAIM AGAINST ORGANISATION												
Employee Compensation claim		A NHS employee (the actor), dishonestly misrepresents a set of circumstances (the action), in order to obtain a compensation claim (the outcome)										
External Person or Organisation / Compensation claim		An individual / organisation (the actor), dishonestly misrepresents a set of circumstances (the action), in order to obtain a compensation claim (the outcome)										
RECRUITMENT												
Agency Worker - Pre Employment Checks	Workforce	Agency staff working for the organisation may not have the right to work, relevant qualification / registration / experience										
Direct Recrutiment - Pre Employment Checks	Workforce	Persons employed / applying to work for organisation may provide false documents / ID / qualifications / experience / registration										
NHS employees / Recruitment process		A NHS employee (the actor), unduly influences the recruitment process. For example a family member or friend serving on the interview panel (the action), for personal gain (the outcome)										

RECRUITMENT	NWSSP	"A NHS employee (the actor), falsely presents themselves as a qualified medical professional (the action) for personal gain (the outcome) A NHS employee (the actor), uses false information or false documents in their real name (the action) to support their to work in the UK (the outcome) A NHS employee (the actor), provides counterfeit identity documents with the intent to deceive (the action), for personal gain (the outcome)" A NHS employee (the actor), produces genuine identity documents that have been adapted or altered (the action), with the intent to deceive (the outcome) A NHS employee (the actor), provides genuine documents such as passports or driving licenses that have been obtained using false information (the action) for personal gain (the outcome)										
PROCUREMENT												
Procurement - Staff collusion	NWSSP	Breach of procurement rules An individual/ NHS employee (the actor) intentionally fails to adhere to procurement rules, including contract splitting, the use of accelerated timescales, conflicts of interest and inappropriate authorisation (the action) for personal gain resulting in a loss to the NHS budget (the outcome) Bribery An individual (the actor) is involved in the offering, giving or receiving of an inducement, gift or hospitality to dishonestly influence another (the action) in order to create a gain resulting in a loss to the NHS budget (the outcome). False quotes and tenders An individual / supplier (the actor) provides false quotes or tenders in the procurement process (the action) resulting in a potential loss to the NHS budget (the outcome). Rigging tenders An individual within an NHS body (the actor), who is involved in the tender process, produces a tender specification or weighting of a tender evaluation to dishonestly favour a particular supplier (the action) resulting in the NHS body not getting true value for the contract awarded due to limiting the potential of others to submit a tender (the outcome).										
Procurement - Post contract	NWSSP	Concealed substitution An individual / supplier (the actor) makes an unexpected change to a contract, work done, or goods and services supplied whilst attempting to conceal this change (the action) resulting in a loss to the NHS budget and / or gain for themselves (the outcome). Duplicate invoices An individual / supplier (the actor) submits more than one invoice for the same product or service (the action) resulting in a loss to the NHS budget for the value of the duplicate invoice (the outcome) False invoices An individual / supplier (the actor) submits a false invoice for a product or service (the action) resulting in a loss to the NHS budget (the outcome) False validation An individual / supplier (the actor) has dishonestly presents information certifying that work done meets agreed standards (the action) resulting in the NHS paying for a service that does not meet the standard required or was agreed in advance (the outcome) Inflated invoices An individual / supplier (the actor) submits false invoices that do not accurately reflect the goods or services provided or contracted to the NHS (the action) resulting in a loss to the NHS budget (the outcome).										

Procurement - Personal gain	NWSSP	Business use An individual (the actor) makes use of NHS supplies for their private medical work or has purchased goods using NHS funds with the intention of selling them for personal gain (the action) resulting in a loss to the NHS budget (the outcome). Personal use An individual (the actor) has purchased goods using NHS funds with the intention of selling them for personal gain (the action) resulting in a loss to the NHS budget (the outcome).										
Procurement - Mis-selling	NWSSP	Contract terms/charges An individual / supplier (the actor) misleads the NHS into entering a contract, or, the NHS into being charged for products or services they have not agreed to (the action) which results in a loss to the NHS budget (the outcome). Product non-existent/underdeveloped An individual / supplier (the actor) misleads the NHS into entering a contract or the NHS is being charged for products or services that do not exist or are wholly under developed or not in existence (the action) which results in a loss to the NHS budget (the outcome).										
Procurement - Contractor collusion	NWSSP	Bid rigging/market division An individual / company (the actor) colludes with other suppliers on bidding on how much they will bid and what they will bid for on NHS contracts (the action) resulting in the NHS not getting true value for the services / goods supplied (the outcome) Price fixing An individual / supplier (the actor) involved in a procurement process conspires with others to agree the price that a particular product, works or service will be sold for to the NHS (the action) resulting in a loss to the NHS budget as the NHS may have been overcharged (the outcome) Production/supply limitation An individual / supplier (the actor) deliberately restricts the levels of supply to NHS bodies in an attempt to increase the price charged (the action) resulting in a loss to the NHS budget of the increased value (the outcome)										
Capital and Estates Procurement	Works and Estates	Actor: External contactors, internal staff who hold financial association or involvement with external suppliers entering into the bidding, quotation and tendering of contracts. Action: •Conflict of interest/staff involved with procurement process/failure to notify of association with external companies in line with Standards of Business Conduct and Declaration of Interest •Failure/breach of working to SFI’s and SOs and manipulation of the tender process, bid rigging, corruptly awarding contracts and contract splitting •Financial bribes and incentives in relation to awarding of contracts •Invoice splitting to keep below threshold of delegated approval limits Outcome: If this type of fraud occurs then the organisation will suffer potentially high value financial loss. Potential committal of criminal offences and reputational damage.										
ASSET SECURITY / USE												
NHS employees / Employee insider issues / NHS assets		A NHS employee (the actor), uses NHS property, such as data, systems, medical and non-medical equipment, vehicles, consumables and supplies for a non NHS purpose (the action) for personal gain (the outcome)										
ACCOUNTS PAYABLE / PAYMENTS												
Petty Cash		Using petty cash to fund unauthorised activities which are not in line with the NHS organisation’s policy. Unrestricted access to the petty cash fund.										

Payment Terminal		This risk relates to payment terminal, also known as point-of-sale terminal or credit card terminal which is a device that interfaces with payment cards to make electronic funds transfers. Payment terminals may be portable card machines allowing payment on the move, others are countertop card machines that plug in and stay put. Payment terminals provide the user with several options via the payment terminals menu selection, including processing a refund. There is a risk of fraud in this area relating to authorising of refunds, a refund could only be processed by entering a supervisor’s code. Payment terminals can be used for the fraudulent transactions when the supervisor code for the payment terminal has not been changed from the original default code.											
Third parties / Payment fraud / Unsolicited requests /	NWSSP	An individual / third party (the actor) requests payment from the NHS where no contract or payment obligation exists (the action) resulting in a loss to the NHS budget (the outcome)											
Employee insider issues / Improper payments	NWSSP	A NHS employee (the actor), uses their knowledge or access to make illicit payments for instance, by creating bogus customer records, (the action) for a gain (the outcome).											
Third parties / Payment fraud / Mandate fraud /	NWSSP	An individual / third party (the actor) outside of the NHS requests a change of bank account details in respect of an NHS supplier (the action) with the intention to divert payments made by standing order, direct debit or bank transfer resulting in a loss to the NHS budget (the outcome)											
Working Arrangements													
Remote Working		This fraud can occur where a member of staff (the actor) works remotely for all or some of their working hours however is completing secondary employment during the same time.											
PATIENT RELATED													
Continence	Community Services	Continence products being re-ordered for deceased patients by residential homes. In addition, products not being returned when a patient passes away.											
Patient Fraud - Travel Costs	Finance	This relates to someone who is claiming NHS funding for travel to hospital which they are not entitled to.											
Overseas/Private Patient	Finance	This relates to the dishonest charging or the deliberate failure to charge overseas/private patients for treatment received. Patients making false claims as being ordinarily resident when not in order to receive free NHS treatment											
Patient Registrations	Primary Care - GMS	Registration details This relates to someone who has used false information about themselves in order to register for NHS services. Registered identity false This relates to someone who has used the identity of another person for the purposes of registering as an NHS patient to access NHS services. Registration address false This relates to someone who has registered for NHS services using an address where they are not a resident.											

Prescription Fraud	Pharmacy/ Medicines Management	Stolen This relates to stolen prescriptions. Altered/amended This relates to a genuine prescription that has been falsified in some manner by adding or changing something on it. Counterfeit This relates to counterfeit prescriptions produced with intent to deceive. Used by someone else This relates to prescriptions used by someone other than the intended patient. Multi-registration This relates to someone registering at different practices using their own identity or an alias, to obtain excess NHS medication or services. Obtained for another This relates to NHS medication obtained for an NHS patient being provided to someone else, including selling, exchanging or sending abroad. Lost This relates to an NHS prescription form being reported as lost by a patient.										
Optical Contractor Fraud	Primary Care - Ophthalmic	Enhanced claims This relates to false or enhanced claims submitted to the NHS by optical practices. For example, claiming higher voucher values or increasing the number of items actually dispensed, i.e. claiming for two pairs of glasses when only one was issued. False claims This relates to false patient claims including claims submitted by optical practices. This includes claims submitted where the patient did not actually attend on the day, the patient never attended, the patient does not actually exist, or the patient was deceased at the time for which the treatment was claimed. Double income This relates to false claims submitted by an optical practice to the NHS for NHS patients who in fact paid privately. Testing/dispensing This relates to dispensing and testing of optical equipment, including unnecessary early recall of patients, dispensing without clinical justification and the dispensing of optical devices and lenses.										
Dental Contractor Fraud	Primary Care - Dental	Dental activity This relates to false claims for dental activity submitted to the NHS for payment which include additional claims, enhancement to claims and splitting courses of treatment. Patient claims This relates to false patient claims by a dental contractor. This includes claims submitted where the patient did not actually attend on the day, the patient never attended, the patient does not actually exist, or the patient was deceased at the time for which the treatment was claimed. Double income This relates to false claims by a dental contractor submitted to the NHS for payment for patients who paid privately.										
General Practice Fraud	Primary Care - GMS	Deliberate misrepresentation of patient list size and/or demographics by health care service providers in order to attract higher funding. For example, older patients who attract higher funding not being removed from the practice list when they are deceased or fictitious patients being created to attach higher funding. Deliberate misrepresentation of additional services data to inflate payments to practice.										
CHARITABLE FUNDS												
Charitable Funds	Finance/Charity	This relates to the fraudulent abuse of NHS charity funds or monies intended for charitable purposes by an NHS employee.										
Locally Identified Emerging Risks												

OOHGP Omnicell Drug Storage	Medical Directorate	Actor: An individual with legitimate access to the Omnicell Medicine Cabinets located within the Cardiff and Vale Our of Hours GP Locations. Action: An individual utilises their access to the Omnicell Machine in order to take medicines/stock for a purpose other than its intended for i.e. for personal use, to be sold on for gain or to be given to a third party who is not entitled to the item.									Informed by ongoing discrepancies across NHS Wales sites	
Iompersonating Medical Personnel	Nursing and People Services	Actor – Individuals who are registered as genuine workers with agencies and third-party persons who are not registered with agencies. The agencies have a responsibility that the person they are supplying is qualified and fit to complete the role allocated. Action – This fraud would occur when a different person attends to complete a shift than that has been legitimately booked. The manner in which this may transpire can differ however the impact and mitigation methods would be the same. Potential scenarios would be: 1. A booking is made by an agency for a legitimate worker on their system to complete a shift. The agency then sends a different person to complete the shift. 2. A booking is made through an agency by a legitimate worker at the agency who states their intention to complete the shift. This worker then “subcontracts” the shift to another individual. Upon attending the shift, the false worker may then either utilise the legitimate workers Agency ID / present an altered genuine ID / produce a fully forged ID badge.									Informed by LPE carried out at CTMUHB	
WGOS CLAIMS	Primary Care - Optometry	Actor: Members of the public taking advantage of the WGOS system and making multiple claims for free eye tests and more than their entitlement to GOS vouchers Action: 1. Members of the public are attending opticians and obtaining an NHS eye test and visual aids free of charge without proof of identity or proof of eligibility. 2. Members of the public are taking advantage of poor practice from opticians and claiming several of these at different opticians due to the appropriate benefit and identification checks not being conducted by the opticians. 3. Contractors create ‘Ghost Patients’. Potential scenarios: - Person attends an Opticians store and books an eye test under the WGOS scheme, receives the test and does not show any proof of identification – these details are false and the person becomes untraceable as a result. - Person attends an Opticians store and does not provide proof of eligibility under the GOS Scheme – resulting in the person receiving GOS services that they are not entitled to. - A person attends a number of opticians and receives GOS services either providing false details, or correct details and either with or without proof of eligibility, and then attends further opticians stores for further GOS services within a short time scale e.g. a person attends 5 opticians stores within a two-week period and obtains five separate eye tests									Informed by high volume referrals at CAVUHB	

Optometry CPD Claims	Primary Care - Optometry	Actor: Opticians or stores who claim Continuing Professional Development payments. Action: 1. Two opticians' stores have made a CPD claim for the same person. 2. A person and store make a CPD claim when they can only claim once. 3. A person is claiming CPD when it has not been completed as part of their job. Potential scenarios: • An optician store makes a claim for CPD for an optician who has left their store, meanwhile that same optician makes a claim from their new store. • An optician makes a CPD claim when they have not completed the work they need to, in order to be eligible for this payment. • Two optician stores make a claim for the same optician. This is likely due to there being no system in place that alerts them of the optician already having an active claim. • An optician makes several claims for the CPD programme from different stores. Outcome:										
WP10 Hospital Prescription security	Pharmacy/ Medicines Management	By staff member taking WP10 precritpion for use in fraud									Informed by current investigation	SM
WP10 Community Prescriptions	Pharmacy/ Medicines Management	Non authorised persons having access to Prescriptions that can then be taken and used in the course of fraud									Informed by Intelligence received via LIN	SM
Staff Leavers - ID, Uniform etc	Workforce and OD / Security	By staff members leaving the organisation and retaining ID cards and uniform etc that allows access to areas that they are no longer entitled or by staff member passing such items to third party to allow access to restricted areas and or impersonation of staff									Informed by Intelligence received via LIN	SM

Internal Audit Progress Report

Audit, Risk and Assurance Committee

February 2025

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 2024/25 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board') to the February 2025 Audit, Risk and Assurance Committee (the 'Committee');
- approve the inclusion of the additional audit, 'Process of Reallocating Vacant Practices' and to accommodate the delivery of this audit by deferring the Partnership Arrangements audit.
- provide a further update on the scheduling of the Welsh Intensive Care System audit; and
- provide an overview of other activity undertaken since the previous meeting.

2. Progress against 2024/25 Internal Audit Plan

There are 33 individual reviews in the 2024/25 Internal Audit Plan, including assurance work completed by our Specialist Services Unit (SSU) over major capital projects.

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

Number of audits in plan:	33
Less audit merger	(1)
Less potential deferral	(1)
Revised total	31
Number of audits at final report stage	10
Number of audits at draft report stage	5
Number of audits work in progress	6
Number of audits at planning stage	5
Number of audits not started	5

The following final reports have been issued since the meeting of the Audit, Risk and Assurance Committee on 12th November 2024:

AUDIT ASSIGNMENT	ASSURANCE RATING
Records Management	Limited
Declarations of Interest	Substantial
Intelligence Led Organisation	Reasonable
End of Life Care	Reasonable

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

3. Summary of Findings

Limited assurance reports are considered by the Audit, Risk and Assurance Committee in detail. The following summary provides the Committee with the main messages from the reports issued since the last meeting on 12th November 2024.

Records Management (limited assurance)

We sought to assess the implementation of the recommendations raised within the 2022/23 internal audit and to retest the agreed objectives.

We found that issues raised in our last report have not been fully addressed. In addition, we identified some additional issues related to the same objectives and raised the following matters:

- adherence to records management practices;
- a sample of unretrievable patient records (both paper and digital) identified;
- two examples of unauthorised access to patient records, due to system access granted;
- inappropriate storage conditions; and
- limited strategies to secure or optimize library / storage space going forward.

Declarations of Interest (substantial assurance)

We reviewed the arrangements for registering and managing potential conflicts caused by the receipt of gifts, hospitality and external interests.

As directed by the revised Health Board policy 'Standards of Business Conduct incorporating Declarations of Interests, Gifts, Hospitality, sponsorship and Honoraria' (the 'Policy') it is the responsibility of the employee for making a declaration. As such, we are unable to provide assurance that everyone that should have completed a declaration has done so. However, within our review we have ensured that declarations that have been completed are actioned and recorded in accordance with the process and the Policy.

To align with the new policy, the Health Board has adapted the declarations process from a manual form to a new automated process via Microsoft Forms. This has been in place since October 2024. The corporate governance hub on ABUHB SharePoint has been updated to reflect this new information.

For completeness we have reviewed the revised policy, in addition to the previous and revised process to ensure declarations have been and are being completed correctly.

We raised two matters, relating to ensuring all staff groups required to complete a submission do so and continuing to remind staff of the Policy requirements.

Intelligence Led Organisation / IMTP (reasonable assurance)

The audit sought to evaluate determine the processes in place to deliver information products to staff and maximise the use of analytics in an appropriate and secure manner.

The Health Board has developed a Data, Analytics and Information Management Strategy to progress its position to become an intelligence-led organisation. The Strategy seeks to address current gaps including the absence of a single coordinated process and an oversight group for producing intelligence products, and digital literacy training and development.

We raised recommendations over the following areas:

- prompt approval of the Strategy;
- an actionable statement of intent regarding Data Quality would be beneficial to underpin the new Data Strategy;
- information products developed outside of Information Services should clearly state where definitions differ to the standard; and
- the proposed project to replace the current SFN tool used within the Planning division should be delivered with appropriate representation from the division to feed in their needs.

End of Life Care (reasonable assurance)

The audit sought to determine if care arrangements for end-of-life (EoL) patients are planned sufficiently in advance to enable their care to be provided in the community and to avoid unnecessary hospital admission.

The Health Board provides a range of resources directed at facilitating advance care planning for end of life, but national audits (National Audit of Care at the End of Life – NACEL) indicate a low incidence of such plans in patient records. Whilst these resources are available and their use encouraged, because planning for end of life is the choice of the patient, the Health Board does not prescribe or control activity in this area. As a result, excepting those few elements which direct intervention decisions which must be actioned (e.g. patient owned 'Advance Decision to Refuse Treatment', Health Board owned 'Treatment Escalation Plans') there is a lack of a documented policy and procedure over its use. We focussed on the completion of Advance Care Plans (ACP) as part of Future Care Planning arrangements and reviewed a sample of hospital admissions.

Consequently, whilst there are numerous contact points and evidence of discussions taking place with patients over care planning (e.g. DNACPR), there is no mandatory requirement for the patient to maintain an ACP. In addition, we found that viewing or determining the completion of an ACP was not always straightforward. Overall, we were unable to conclude if ACPs were completed as required, due to the lack of a mandatory framework and whilst we saw evidence of discussions / contact points in relation to end of life planning, we were unable to determine if this was fully complete. Therefore, we recommend in the first instance, that the Health Board set

out the standards of documentation and the level of completion required for each EoL patient, including discussions and contact that takes place.

NACEL audits report on a wide range of aspects of care provided to patients at end of life and, as national reviews, allow health boards to compare their practices with other health care organisations. Recommendations from the latest audit (2022) included improvements to aspects of advance care planning and were published in mid-2023. The Health Board has acknowledged these issues in an action plan, but had not addressed them at the time of this audit.

4. Welsh Intensive Care System

At the last Committee, we highlighted that the funding arrangements are still to be confirmed by the Welsh Government for the Welsh Intensive Care System. As set out, we will commence the audit following the conclusion of this process, due to the impact on the audit scope. We still have no update to provide to the Committee at this stage.

5. Additional Audit Inclusion

The Health Board requested an additional review over the Process of Reallocating Vacant Practices. Following discussion and consideration, we can deliver this audit as an urgent priority, to provide additional assurance over a high-profile area. To achieve this, we are seeking **approval** from the Committee for the inclusion of the Process of Reallocating Vacant Practices audit within the 2024/25 Internal Audit Plan.

To accommodate this review, we propose deferring Partnership Arrangements, as the arrangements are within the same audit domain and would be a similar sized review. Therefore, we are seeking **approval** to defer this audit into a future audit plan.

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 **approve** the deferral of Partnership Arrangements and **approve** the inclusion of the Process of Reallocating Vacant Practices audit.

Appendix A: Progress against 2024/25 Internal Audit Plan

Audits	Status
Financial Sustainability	Planning
IMTP – Service Delivery Plans (merged with Intelligence Led Organisation)	Final Report
Contract Management	Work in Progress
Facilities Stock	Final Report
Performance Framework	Planning
Embedding of Policies	Draft Report
Declarations of Interest	Final Report
Divisional Governance Arrangements	Draft Report
Directorate Review - Mental Health and Learning Disabilities	Draft Report
Maternity Services Improvement Plan	Work in Progress
End of Life Care	Final Report
Health and Safety (comprising of two parts)	Part One: Complete Part Two: Planning
Waiting List Management	Not started
Partnership Arrangements	Request for Deferral
Process of Reallocating Vacant Practices (potential replacement)	Work in Progress
Medical Equipment and Devices	Work in Progress
Records Management	Final Report
Job Planning	Work in Progress
Staff Culture	Draft Report
Medical E-Rostering	Planning
Providing Care to Asylum Seekers and Refugees	Final Report
Follow-up of High Priority Recommendations	Planning
Welsh Intensive Care System	Not started
Analytics and Information Use (Intelligence Led Organisation)	Final Report (merged)
Technical Continuity	Work in Progress
Electronic document and records management solution	Not started
Capital Systems/Major Project Provisions (not separately provided)	Not started
Nevill Hall RAAC	Final Report
Estates Assurance – Energy Management	Final Report
Newport East HWBC	Final Report
NHH Regional Satellite Centre	Not started
The Grange A&E Expansion	Draft 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.

Records Management

Final Internal Audit Report

2024/25

Aneurin Bevan University Health Board



Limited Assurance

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Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

ABU-2425-16

December 2024

07 February 2025

18 February 2025

Paul Solloway, Director of Digital

Stephen Chaney, Head of Internal Audit

Krisztina Kozlovsky, Internal Audit Manager

Mair Evans, Principal Auditor



GIG
CYMRU
NHS
WALES

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



Executive Summary

Purpose

To assess the implementation of the recommendations raised within the 2022/23 internal audit and to retest the agreed objectives.

Overview

We have concluded **limited** assurance on this area. We found that issues raised in our last report have not been fully addressed. In addition, we identified some additional issues related to the same objectives. The following matters require urgent management’s attention:

- adherence to records management practices;
- a sample of unretrievable patient records (both paper and digital) identified;
- two examples of unauthorised access to patient records, due to system access granted;
- inappropriate storage conditions; and
- limited strategies to secure or optimize library / storage space going forward.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Furthermore, we identified the following minor issues, which are not included in the matters arising list above, but are detailed for completeness:

- the uptake of the supplementary awareness session, provided by the Health Records Team, is low;
- there is no centralised system to track the daily availability of ward clerks;
- the future plans for the use of Online House are still not confirmed; and
- there is no platform to share patient records with other health boards securely.

Scope & Assurance Summary

Objectives		Related Findings	Assurance
1	Appropriate policies, procedures and guidelines are in place for the management of records that encompasses the full records lifecycle.	1	Reasonable
2	Record quality is ensured. Documentation and records are kept to an appropriate standard	2,3,4	Limited
3	Records storage facilities ensure that records are protected from unauthorised access, destruction or theft, and from accidental damage from environmental hazards.	5,6	Limited
4	Physical records are transported appropriately, tracked and records are available when and where needed by operational staff.	7,8	Limited

Management Actions

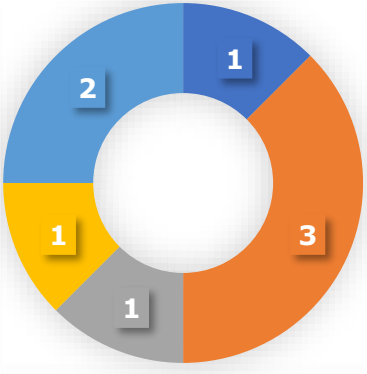


High Priority



Medium Priority

Themes



- Approvals
- Information, Data Quality & Data Accuracy
- Lessons Learnt
- Physical Security
- Quality, Safety & Patient Experience

Risk Types

- Financial Loss
- Legal & Regulatory Non-Compliance
- Quality or Safety Issues
- Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: Appropriate policies, procedures and guidelines are in place for the management of records that encompasses the full records lifecycle

Reasonable

Policies, procedures and guidelines

There are 106 standard operating procedures (SOPs) and policies in place at the Health Board, from which we have identified the following 10 Policies and SOPs as key:

Ref.	Policy Reference	Title of Policies and SOPs
1	SOP-DHR-0036	Quality Assurance
2	SOP-DHR-0037	DHR Retention and Destruction
3	SOP-DHR-0025	Emergency Admissions – scan on demand
4	SOP-LIB-0015	Transportation of records by WAST
5	ABUHB/IMT/0726	Clinical Record Keeping Policy
6	ABUHB/IMT/0405	Recording of Patients by ABUHB Staff – Use and Storage of Audio Recordings and Images Policy
7	ABHB/IMT/0162	Patient information: Policy for Ensuring Data Quality
8	SOP-STC-0006	Tracking
9	SOP-STC-0007	Stores & Archive
10	ABUHB/IMT/ 1042	Records Management Code of Practice

We reviewed the key policies and SOPs in detail and found that were available on Sharepoint. We found that the SOPs were aimed at staff within the Health Records team, while the policies were applicable for a wider audience. Both SOPs and policies remained within their review period, except for two local policies (numbers 7 and 10 listed above).

Training

The provision of records management training is a legislative requirement. Compliance with the regulatory requirements is ensured through the Information Governance (IG) training, with the IG Handbook including a 'Health records' section (section 2.5). The completion of all elements of the IG training is mandatory, and the results are formally monitored through ESR, with related KPIs reported back to the divisions every three months. We note that this data also presented to the Finance and Performance Committee.

The Health Records team provided bi-monthly, non-compulsory records awareness sessions throughout 2024, specifically for ward clerks. However, the uptake of these sessions is low, with 16 ward clerks attending (average 3.2 attendees per session), representing 10.88% of the ward clerk workforce.

Hierarchy

During our fieldwork, we visited 18 wards and identified that 39% of the wards did not have a ward clerk on site. Although there are opportunities to use bank staff to address staffing shortages, we still identified gaps. We found that where ward clerk positions were vacant the quality of records management was adversely impacted. (See further comments related to records quality under Objective 2).

Escalation process

Datix is used as an escalation route at the Health Board, however, this process is not consistently adopted by the wards. (See further information on Datix data for 2024 under Objective 4). We also note that robotic functionality has been implemented to identify exceptions through data comparisons, with the aim to prevent repeated occurrences. While the results are shared on the organisation's intranet, the number of monthly exceptions remained consistently high over the last six months. In addition, we also reviewed the live ADT (Admission, Transfer & Discharge) Power BI dashboard for January 2025 and two monthly reports to the Digital Records & Patient Engagement Group (RPA) for April and October 2024.

Key Findings		Risk & Impact	Agreed Management Action
1	Lesson learnt The escalation process through the Health Board is inconsistent, with issues prioritised differently across the organisation. We observed examples of record management issues raised at the Royal Gwent Hospital (RGH) and Nevill Hall Hospital (NHH), but no formal actions have been initiated resulting in sustained improvement. Furthermore, robotic functionality has been fully implemented to identify data issues with the output generated as an automatic email detailing the problem. While this approach appears sound, in practice, it results in multiple emails being sent to the same individual regarding issues across multiple patients. We note that the volume of the system-generated emails is significant and due to the high number, there is a risk that they may not be fully acknowledged or addressed by responsible individuals.	Record management issues may go unaddressed.	Agreed Action: Datix is the incident reporting system for the Health board. We will highlight the inconsistent use of this system to the system lead and health and safety manager, and recommend more training offers, to training on documenting the formal actions that have been taken, as part of the management review. We recognise that the output from the robotic functionality requires analysis, and a more targeted follow up is necessary for improvement. Expected Evidence of Implementation: The Health and Safety team and Datix system lead would be required to provide evidence of training. Datix training sessions are scheduled regularly and staff are directed to the training video on the intranet for reporting incidents. We will review the current process with RPA and implement follow up meetings with individual directorates to support action. Documented evidence of this will be available for audit purposes.
		Medium Priority	Officer: Health and Safety Manager and Datix System Lead. Head of Health Records - DHR Date: 30 June 2025
	Theme: Lessons Learnt	Control Operation	

Patient records at the wards are populated by nurses, clinicians, and other relevant staff. The wards are mandated to utilise and recycle soft yellow Digital Health Record (DHR) folders for patient records, and these folders are required to be tracked in the Welsh Patient Administration System (WPAS) for monitoring purpose. The ward clerks have responsibility to set up, check, organise and track the DHR files before the files are sent for coding and scanning.

We visited 18 wards across the Health Board. As part of our fieldwork, we found that, in addition to the DHR folders, some wards also used hard ring binders, primarily for nursing notes. These binders were typically merged with the corresponding DHR folders at the end of the process but were not formally recorded in the system. We have included a summary of our findings below:

Hospital	Wards visited	Summary of findings
The Royal Gwent Hospital (RGH)	- MAU - D1 West - C5 West ward (ex-St. Woolos) - C6 East ward (ex-St. Woolos)	75% of the files had general filing issues including loose papers, blank forms etc. We also identified patients who were transferred here without their physical records.
Nevill Hall Hospital (NHH)	3.1 Glan Ebbw ward 4.2 Crickhowell ward	92.31% of the files had general issues. We also identified some patients who had not been formally discharged within CWS, however, they had already left the hospital.
Ysbyty Aneurin Bevan (YAB)	- Ebbw ward - Shirhowy ward	75% of the files had issues like loose papers, polly pockets and blank forms. We also found overflowing files and files which have not been raised in WPAS and patients who were transferred here without their physical records.
Ysbyty Ystrad Fawr (YYF)	1.1 Fraility ward 2.1 Oakdale ward 2.2 Rhymney ward 3.2 Penalta ward - MAU	70% of the files had general filing issues. We also found patients who were not formally discharged within CWS, however, they had already left the hospital.
The Grange University Hospital (GUH)	- AMU - C1 ward - Butterfly section - A2 ward	47% of the files had general filing issues.
County Hospital	- Oak ward - Rowan ward	All files had general filing issues. In addition, we found some supplementary records, files with mixed patients records and multiple records where the patient's ID was missing. Furthermore, we also found transferred patients without their physical records and files which have not been tracked to the ward in WPAS.
Chepstow Community Hospital (CCH)	Cas Gwent ward	100% of the files had general filing issues. We also found that files were not raised and tracked in WPAS, there were substantial supplementary notes left behind at the ward. Furthermore, we found original records from Cardiff & Vale University in a brown envelope.

We reviewed a sample of records for five patients from each ward, prior to their digitalisation into Clinical Workstation (CWS) and where we found issues we extended our sample selection. In total, we reviewed records for 90 patients. In addition, we selected two services (children and mental health), where currently the records are not digitalised, and reviewed a sample of five patients for each service.

In total, we found that references to the quality checks (e.g. audit checks) were included in the relevant policies. While many of these checks are being performed regularly, we found that they were not formally evidenced and the timing of the checks often occurred toward the end, or near the end of the digitalisation process. This limited the opportunity to address or rectify any issues identified during the checks.

At Online House, large scanning machines are used, and elsewhere, smaller machines are in place for scanning purposes. Invariably, these lead to a variance in the quality and timing of record digitisation across the Health Board.

However, we note that a new digital Welsh Nursing Care Records (WNCR) system was launched with the aim to reduce the number of paper forms used on the wards. Furthermore, there are plans to roll out an electronic Prescribing and Medicines Administration (ePMA) system to improve safety and patient experience.

Key Findings		Risk & Impact	Agreed Management Action
2	Paper records From our sample review of records for 90 patients we found evidence of poor records management. We also found issues, such as records not being kept in chronological order, files overflowing and the absence of patient IDs on certain records. We came across two instances where multiple patient records were bundled together in one file.	• Poor record management • Impact on patient care	Agreed Action: Although it is not evidenced that ward clerks were in place in each of these wards, the lack of records management does require to be addressed across the organisation. The service has previously requested for local health records management training to be mandatory. This was not approved and therefore there is limited engagement at Health Records Awareness sessions that are scheduled bi-monthly. We recommend mandated Health records management training for all ward clerks during induction, alongside refresher sessions, to provide a more in-depth understanding of the processes involved. Although there is a national Health records Management Module incorporated in the mandatory Information Governance training, this does not provide in-depth records management training in ABUHB processes. We are implementing a schedule of ward visits and training updates across the Health Board, to promote best practice and provide evidence of where there are gaps that need to be addressed but there is a resource gap to undertake extensive training across all sites. Discussions will be held with the Executive Director of Nursing on including some of these elements in the Ward Accreditation Programme.
			Expected Evidence of Implementation: Microsoft list with information on all wards and scheduled dates to visit, to commence from 21/02/2025. Microsoft form designed to gather information from the ward clerks across the Health Board regarding current records management processes, which we can analyse. A formal report can be generated from these findings. We can proactively support wards with records management training based on the evidence from the ward visits but there is a resource gap to undertake extensive training across all sites.

		High Priority	Officer: Head of Health Records - DHR Date: 31 December 2025
	Theme: Information, Data Quality & Data Accuracy	Control Operation	
3	System alerts We found some examples where mental capacity limitations are not always accurately reflected on CWS. While there are warning flags available in the system to alert system users about specific conditions of a patient, these flags are required to be switched on manually. We found six patients where the "This is me" document was on file, but no flag was turned on within CWS. We also note that Lasting Power of Attorney (LPA) is listed as a clinical alert in CWS, which links through from WPAS keynotes. This alert is added to WPAS by the Health Records Team when the LPA document is received for scanning, and this should also be recorded at ward level when documents are presented.	Safeguarding of vulnerable adults	Agreed Action: We recommend that this forms part of the basic WPAS training for new starters, and also the refresher WPAS training. We will link in with the WPAS systems team to ensure this is incorporated into the new training packages that are being developed as part of the Planned Care Academy work.
		Medium Priority	Expected Evidence of Implementation: Evident in training and guidance documentation for all staff.
	Theme: Quality, Safety & Patient Experience	Control Operation	
4	Spot checks Spot checks of patient records are conducted regularly; however, these assessments primarily take place at or near the final stages of the digitalisation process or following its completion. As a result, it is challenging to address any issues identified at this point of the time.	Quality issues may not be rectified	Agreed Action: The Information Governance Team are in the process of gaining approval for an internal audit team who will undertake regular spot checks on wards, with data quality and record keeping being part of the remit.

			Expected Evidence of Implementation: Audit reports from the newly established IG Audit team.
		Medium Priority	Officer: Head of IG & DPO Date: 31 March 2026
	Theme: Information, Data Quality & Data Accuracy	Control Design	

We found a wide range of record storage issues with the sites visited, as detailed below. However, we found that records previously stored at Llangennech have been destroyed as per policy or moved to Online House and NHH.

Visited Location	Post code	Date of visit	Number of areas used for storage	Storage conditions were appropriate	Records stored securely	Patients' data was properly stored
Nevill Hall Hospital (NHH)	NP7 7EG	11/12/2024	2	No	No	Yes
St. Cadoc's Hospital – Mental Health	NP8 3XQ	16/12/2024	3	No	No	No
St. Cadoc's Hospital – The White Valley Centre	NP8 3XQ	16/12/2024	3	No	No	No
On-line House	NP10 8BA	17/12/2024	3	Yes	Yes	Yes

Records are currently digitalised at two main locations within the HB (NHH and Online House). While the volume of records in storage has significantly reduced since our last visit, due to the lifting of embargos, the current retention policy mandates that records must be retained for six weeks after scanning. As the result, the organisation will require ongoing space for the storage of scanned records, preparation of records for scanning and operation of the scanning machines. Currently, there are no formal plans to continue or replace the existing storage facility at Online house, despite the lease expiring in October 2026.

Key performance indicators (KPIs) are set and calculated for monitoring purposes, by the Records Management Team, to understand scanning capacities. But there is no formal monitoring in place as to how many records may be processed for coding and scanning purposes from the wards, and which wards / areas are behind with submitting records for the digitalisation process.

Key Findings		Risk & Impact	Agreed Management Action
5	Security of patient records <u>NHH:</u> The B3 storage block and related courtyard remained shared with Works & Estates. We also found that the gate to the courtyard was left wide open, and recyclable materials, including metals and cardboards were deposited in the area. Additionally, a couple of vehicles were parked in the courtyard. The lift to the Filing library had been out of service for the past two months, with maintenance staff actively working on it. As a result, we were asked to access the library through the back door. While the lift is equipped with a digital lock and is located within the building, the back door, opens from the courtyard, and was operated by a single metal key. Furthermore, we note that on the day of our visit, one of the keys to the backdoor was with OTIS (the lift contractors), and the other key was with Works & Estates. Subsequently to our visit, we were told that	Unauthorised access to patient records	Agreed Action: The B3 storage block at Nevill Hall has been a communal area, shared with Works & Estates, for 20+ years. The courtyard area is a service area for works & estates with vehicular access required. Access is also required for delivery of records into this facility. The gates are locked out of hours. This area is for archived records, therefore limited access by health records staff. Records are stored in terminal digit order, therefore access to the WPAS system is required to access a specific record. This reduces the risk of unauthorised disclosure. Works & Estates staff are bound by the same rules of confidentiality as all Health board staff. The lift to the filing library is now repaired and operational. The Mental Health Business case has been approved with 3 WTE, and a program of work is due to commence to start and

	the parts to the lift was ordered, and the repair was scheduled to be completed on 14/01/2025. <u>St. Cadocs:</u> Although we did not observe any files stored in the corridors during this visit, we noted that several of the entrance doors remained outdated and did not provide adequate security to patient records.		remove records from St Cadocs for scanning. Priority will be given to areas that have inadequate security. Work is ongoing to configure the XDS Intelliscanner software and electronic document management system with the new categories required, and AD groups are required to be configured for some services. When the scanner configuration and groups are tested and assured, we will commence. Standard operating procedures and work packages will be developed. A group has been setup to develop options for the future of online house when lease expires in October 2026. Expected Evidence of Implementation: Reduction of records held at B3 due to the ongoing destruction process and at St Cadocs due to scanning.
		High Priority	Officer: Head of Health Records – DHR Date: 31 December 2027: complete destruction of deceased records in B3 (2016, 2017 & 2018 deceased records). Mental Health and Family and Therapy records: 30% complete over five years (2030).
	Theme: Physical Security	Control Design	
6	Storage conditions We found that storage conditions at St. Cadocs were inappropriate (e.g. leaks through the ceiling, high humidity levels etc). We also found incorrect storage practices in operation to store patients' records (e.g. collapsing boxes, loose patients' records) creating opportunities for unauthorised access to patients' files).	Records might get contaminated and damaged	Agreed Action: The Mental Health Business case has been approved with 3 WTE, and a program of work is due to commence to remove records from St Cadocs for scanning. Priority will be given to areas that have inadequate security. Work is ongoing to configure the scanners with required categories and when this is complete, work will begin.

These issues at St. Cadocs were in-line with our previous findings.		Expected Evidence of Implementation: Reduction of records in St Cadocs will reduce over time when scanning commences.
	High Priority	Officer: Head of Health Records - DHR Date: 30% completed over five years (2030)
Theme: Information, Data Quality & Data Accuracy	Control Design	

Systems in place

The Welsh Patient Administration System (WPAS) is used to track the Digital Health Record (DHR) folders which includes the patients’ records. After the records are scanned, they are stored within Clinical Workstation (CWS). We note that beside the scanned records, CWS also holds manually inputted personal data for each patient. However, we note that patients’ video and audio records are not stored here or any of the physical libraries. In addition, a new digital Welsh Nursing Care Records (WNCR) system was launched recently which is linked to WPAS but not CWS.

We also note that there are formal rules to ensure scanning on demand is completed, for example: if scanning requests are marked as “urgent” they are prioritised. We reviewed a sample of records for 90 patients across the Health Board and note that 53.3% of them were not sent for scanning promptly. The longest time being 207 days and the top five timeframes being: 207, 143, 123, 84 and 69 days with the average time that records were not sent for scanning being 27 days. We note that these findings mainly related to wards located at County and Chepstow Community Hospitals, where we found ward clerk shortages.

We also note that there are services which do not feed into the main clinical records, as such, they manage their own records, which are not digitalised. As part of this audit, we selected two services (Children and Mental Health Services) for review. The records for these services are kept in dedicated libraries and the databases (e.g. Children Health Records are stored in Cypris 4.3, Mental Health Records are stored in WCCIS – Welsh Clinical Care Information Service) which do not allow tracking of the records. In addition, neither of these systems use CRN codes, which is used by CWS, for patient identification purposes. We note that these systems have their own codes and methods to search for patients, as a result, these different databases are not easily linkable. Therefore, sometimes it can be challenging to retrieve a complete set of records for a patient.

Records retrieval

In our previous audit, we observed a backlog of paper records awaiting digitalisation. However, this has now been fully cleared. While it is planned to digitalise all records at one point, there are services where the digitalisation process has not been rolled out yet (e.g. mental health, children’s health and therapies).

Transfer of records

We note that there is no formal tracking of records in place when patients’ files are transferred between locations (e.g. in sealed envelopes or boxes). It is the responsibility of the departments or individuals to ensure that the correct delivery takes place.

Furthermore, we note that original patient records must not be sent out from the Health board; as only copies should be shared. We were told that when a ward clerk is unavailable to make copies original records are occasionally sent out and retrieving these records later in the process can be challenging. We came across one case where original patient records were received from Cardiff & Vale University Health Board, and these records remained at the ward after the patient was discharged.

Missing records

There is a formal reporting on missing / lost records as part of the Information Governance incidents reporting to the Finance and Performance Committee. However, the underlying data for this reporting is taken from Datix, which is currently not used the same way across the Health Board. As such, the report does not give an accurate picture of the missing / lost patients’ records. We also note, that missing records statistics are currently included in the IG report to Digital Delivery Oversight Board.

In 2024, 290 Health Record Incidents have been raised in Datix, from which 15.17% was still open as of 10th January 2025, with the oldest one raised in March 2024. The report included the following main categories:

Ref.	Description	Number of incidents	%
1	Documentation missing (e.g. part of the file) or missing health records (e.g. the full file)	107	36.90%
2	Incorrect information documented	52	17.93%
3	Documents misfiled in healthcare record (wrong patient)	35	12.07%
4	Other – not specified	35	12.07%
5	Information not recorded in the health record	16	6.21%
Total		245	84.48%

Furthermore, we reviewed the missing records tracking sheet for 3 months (Sep-Oct-Nov) at On-line House and note that seven patients’ records were still missing. We were also told that some of these items might be recorded in Datix, however, it is likely that not all of them were included.

Key Findings		Risk & Impact	Agreed Management Action																					
7	Access to paper records We reviewed records for 90 patients from 18 different wards (see ward details listed under objective 2), we found the following issues: <table><tr><th>Ref</th><th>Description of the issue</th><th>Number of patients</th></tr><tr><td>1</td><td>The alive / deceased patient file was not sent for scanning.</td><td>47</td></tr><tr><td>2</td><td>The patient was not formally discharged within 24 hours after left the hospital in CWS, and physical records were left behind at the ward.</td><td>4</td></tr><tr><td>3</td><td>The Patient was transferred without physical patient record within the HB.</td><td>4</td></tr><tr><td>4</td><td>The Patient was transferred with the physical records within the HB, but the DHR files were not tracked to the new location in WPAS.</td><td>4</td></tr><tr><td>5</td><td>No patient file was raised in WPAS during the inpatient period or after the discharge at the time of our visit.</td><td>10</td></tr><tr><td>6</td><td>Various supplementary paper records left behind after the patient's DHR file was sent for scanning.</td><td>8</td></tr></table> We note that many of the issues outlined above resulted from the pro-longed absence of the local ward clerk (for example: - no ward clerk worked at the Cas Gwent ward at Chepstow Community Hospital in the last 6 months; or - the Health Records Services were provided by temporary staff who had no access to any of the health records systems (e.g. WPAS and CWS).	Ref	Description of the issue	Number of patients	1	The alive / deceased patient file was not sent for scanning.	47	2	The patient was not formally discharged within 24 hours after left the hospital in CWS, and physical records were left behind at the ward.	4	3	The Patient was transferred without physical patient record within the HB.	4	4	The Patient was transferred with the physical records within the HB, but the DHR files were not tracked to the new location in WPAS.	4	5	No patient file was raised in WPAS during the inpatient period or after the discharge at the time of our visit.	10	6	Various supplementary paper records left behind after the patient's DHR file was sent for scanning.	8	- Unauthorised access to patient records - Unretrievable patient records - Loss of patient records	Agreed Action: The lack of records management does require to be addressed across the organisation. The service has previously requested for local health records management training to be mandatory. This was not approved and therefore there is limited engagement at Health Records Awareness sessions that are scheduled monthly. We recommend mandated Health records training for all ward clerks during induction to provide a more in-depth understanding of the processes involved. We are implementing a schedule of ward visits and training updates across the Health board to promote best practice and provide evidence of where there are gaps that need to be addressed but there is a resource gap to undertake extensive training across all sites. A board development session will also be undertaken on records management to improve support by the executive team and independent members. Expected Evidence of Implementation: A Microsoft list with information on all wards and scheduled dates to visit, to commence from 21/02/2025. Microsoft form to gather information from the ward clerk regarding current processes which we can analyse and support where required. A formal report can be generated from these findings.
Ref	Description of the issue	Number of patients																						
1	The alive / deceased patient file was not sent for scanning.	47																						
2	The patient was not formally discharged within 24 hours after left the hospital in CWS, and physical records were left behind at the ward.	4																						
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5	No patient file was raised in WPAS during the inpatient period or after the discharge at the time of our visit.	10																						
6	Various supplementary paper records left behind after the patient's DHR file was sent for scanning.	8																						

			The Information Governance Team are in the process of establishing an internal audit team who will undertake regular spot checks on wards, with data quality and record keeping being part of the remit.
		High Priority	Officer: Head of Health Records – DHR Head of IG & DPO Date: Health Records – 31 December 2025 and IG – 31 July 2025
	Theme: Quality, Safety & Patient Experience	Control Operation	
8	Access to systems We found that only two out of 18 wards, that we have visited, currently have ward clerks with “write access” to WNCR and were regularly tasked inputting data, such as inpatient notes related to ambulance bookings and assisting with patient discharge records. While there is an expectation that all ward clerks will be required to perform these duties in the future and possess the necessary skills to use WNCR accordingly, it is important to note that only 34 ward clerks received training and were granted access to WNCR in 2024. During our fieldwork, we noted that in the absence of a ward clerk, records management tasks were delegated to a Health Care Assistance (HCA), however, certain tasks remained incomplete, as the HCA did not have the same level of system access as the ward clerk (e.g. access to CWS and WPAS).	• Inconsistent roles and responsibilities • Insufficient training	Agreed Action: To ensure WNCR training sessions are available to ward clerks.
			Expected Evidence of Implementation: Training logs.
		Medium Priority	Officer: Chief Nursing Information Officer (CNIO) Date: 31 July 2025
	Theme: Approvals	Control Design	

Appendix A

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	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.
	Advisory	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 Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

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Public Sector Internal Audit Standards

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Declaration of Interests

Final Internal Audit Report 2024/25

Aneurin Bevan University Health Board



Substantial Assurance

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Review Reference
Fieldwork
Executive Sign Off
Audit Committee
Executive Lead
Audit Team

ABUHB-2425-07
January 2025
February 2025
February 2025
Director of Corporate Governance
Stephen Chaney, Head of Internal Audit
Rhian Gard, Audit Manager



GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd

Shared Services
Partnership
Audit and Assurance Services



Executive Summary

Purpose

We reviewed the arrangements for registering and managing potential conflicts caused by the receipt of gifts, hospitality and external interests.

Overview

We have concluded substantial assurance on this area. As directed by the revised Health Board policy 'Standards of Business Conduct incorporating Declarations of Interests, Gifts, Hospitality, sponsorship and Honoraria' (the 'Policy') it is the responsibility of the employee for making a declaration. As such, we are unable to provide assurance that everyone that should have completed a declaration has done so. However, within our review we have ensured that declarations that have been completed are actioned and recorded in accordance with the process and the Policy.

To align with the new policy, the Health Board has adapted the declarations process from a manual form to a new automated process via Microsoft Forms. This has been in place since October 2024. The corporate governance hub on ABUHB SharePoint has been updated to reflect this new information.

For completeness we have reviewed the revised policy, in addition to the previous and revised process to ensure declarations have been and are being completed correctly.

There are two matters arising, relating to ensuring all staff groups required to complete a submission do so and continuing to remind staff of the Policy requirements.

It is important to note, we have raised low findings which are opportunities for enhancement, and these are discussed in the report on page 2. They do not impact the overall opinion and are highlighted for management information.

Scope & Assurance Summary

Objectives		Related Findings	Assurance
1	The requirements of the Policy incorporate the principles, it is up to date and widely available to staff	-	Substantial
2	Gifts, hospitality and external interests involving employees and independent members are processed correctly in accordance with guidance	1	Substantial
3	Effective management of declarations of interests including maintenance of a register of interests	2	Reasonable

Management Actions

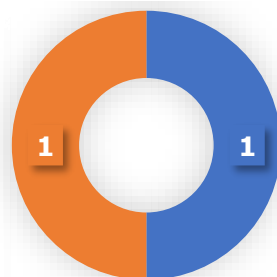


High Priority



Medium Priority

Themes



■ Policies & Procedures

■ Training & Development

Risk Types

Public Perception & Reputational Risk

Low Priority Findings for Management Consideration:

1. We found seven exceptions from our sample of 20 where the old manual forms were not completed correctly, three of them did not have an employee signature and four of them did not contain line manager approval.

We have not raised this as a matter arising as the automated process, via Microsoft Forms, addresses this issue at the point the declaration is made. The respective line manager is required to review, approve the declaration and assess any non-compliance identified via an exception report. If required, an escalation to the Director of Corporate Governance is undertaken to progress a declaration. The new process should eliminate these instances going forward, once the process is embedded.
2. We found one instance where the manual form did not match the Register of Declarations of Interests. The full declaration was made correctly; however, only partial details were added to the Register.
3. Within our testing we found some employee declarations dated pre 2020, there is a risk that circumstances may have changed and may need to be refreshed. Sending out regular reminders may remind staff of their responsibility.

Findings & Agreed Action Plan

Objective 1: The requirements of the Policy	Substantial
The Health Board’s revised policy ‘Standards of Business Conduct incorporating Declarations of Interests, Gifts, Hospitality, sponsorship and Honoraria’ (the ‘Policy’) sets out the standards expected of all employees and Independent Members. The revised policy is more user friendly, with numerous relevant examples for staff to refer to, with an emphasis on the employee completing the declaration when necessary. The Policy was presented to the Audit, Risk and Assurance Committee in May 2024 and subsequently, the Workforce & Organisational Development Policy Group, before it was formally approved by the Board in September 2024. The Policy is available to all employees via the Health Board’s intranet, within the Corporate Governance hub. The Policy makes specific reference to the Nolan Principles and is aligned with the Health Board’s Standing Orders. The Audit, Risk and Assurance Committee receive the Declarations of Interests Register and an overview of the gifts, hospitality, honoraria and sponsorship activities within the Health Board on an annual basis. The Register for Board Members and Independent Members is published on the Health Board’s website.	

The Policy comments in detail on the roles and responsibilities of Health Board employees and Independent Members, it also details the capture, approval and management of gifts, hospitality, honoraria or sponsorship. All employees and Independent Members have a personal responsibility to volunteer information regarding gifts, hospitality, honoraria and sponsorship including the offers that have been declined.

The previous process focused on a manual form being completed and approved by the line manager, the new automated process is completed via Microsoft Forms which notifies the Corporate Services team and the respective line manager for approval. A reminder is sent to the line manager if this is not approved promptly.

We selected a sample of 20 declarations for testing and whilst overall, the Policy was adhered to, we found one example of the acceptance of a £30 voucher (although the individual was absent from work at the point of receipt). This was accepted in April 2024, prior to line manager approval in November 2024. It is likely the declaration (and subsequent approval) was submitted in response to the issue of the Policy. Although not in accordance with the Policy, the previous policy was less specific over the acceptance of vouchers (although the receipt of cash was still strictly prohibited). However, the approval by the line manager was still a requirement and given the nature of the gift (a gift voucher) it should normally be allocated to a charitable fund instead. During our review, we identified another two instances of a gift voucher being accepted (in similar circumstances, but outside of our sample selection).

Reminders to areas regularly in receipt of gifts going forward would help ensure the process is adhered to.

Key Findings		Risk & Impact	Agreed Management Action
1	Monetary Value Gifts We found two exceptions from 20 sampled where declarations were made after the benefit was approved; one was concerning a trolley for a ward and the other one was a £30 voucher for an individual which was received in the person’s absence but was over the £25 threshold and in the form of a gift voucher. Whilst the policy allows, in some instances, gifts to be received (e.g. where it may cause offence to the donor), the declarations should be made (and approved) prior to the acceptance of the gifts. Furthermore, any cash, vouchers etc. should be donated to a charitable fund instead.	Non-compliance with the Standards of Business Conduct Policy through inappropriate gifts accepted.	Agreed Action: As set out within the Standards of Business Conduct Policy (section 14), awareness sessions will be held with managers to set out the requirements of the Policy and ensure these are further cascaded to staff. The Policy also sets out that the importance of continued compliance will be referenced in induction programmes.
		Medium Priority	Expected Evidence of Implementation: Evidence of awareness sessions and inclusion of Standards of Business Conduct in the corporate induction programme.
	Theme: Training & Development	Control Operation	Officer: Director of Corporate Governance Date: March 2026

The Policy comments in detail on the roles and responsibilities of employees and Independent Members and the maintenance of a Register of Interests.

The responsibility for declaration resides with the individual employee or the Independent Member. A judgement may be required in individual circumstances, regarding the nature for a declaration to be made. However, to support this, advice is available from the Corporate Services team and escalated, if required, to the Director of Corporate Governance. The Policy states that where there is an element of doubt, a declaration should be made for completeness and complete transparency. However, where there is a mandatory requirement for a declaration to be made (including a nil submission) for some staff groups, there is no control currently that ensures that each of these individuals have completed the submission. There is a benefit to reminding staff that are required to complete a submission on a regular basis, including any follow-up reminders for non-compliance.

The new automated process on Microsoft Forms requires an employee submission and line manager approval, this forms part of a Register of Interests, maintained by the Corporate Services team. The team are responsible for ensuring that a Register of Interests is established and maintained as a formal record and the details of Executive Directors and Independent Members are annually declared through the Audit, Risk and Assurance Committee and published on the Health Board’s website. This is completed annually, and is underway for 2025.

We completed detailed testing on a sample of 20 declarations including Executive Directors, Independent Members and other Health Board staff. We tested the completeness of the submissions, line manager approval and reconciliation with the Register of Interests. We found most instances where the process was not adhered to, within the old process through a manual completion of forms, but the updated process should reduce the occurrence rate moving forward.

Key Findings		Risk & Impact	Agreed Management Action
2	Mandatory Declarations Whilst it is the responsibility of individuals to declare interests, there is a requirement for some staff groups (e.g. Band 8A and above) to complete a mandatory declaration (either nil or otherwise). Currently, there is no central process (including reminders) for ensuring all staff required to do this complete the declaration process in a timely manner.	There is a risk that mandatory staff groups, required to complete the declaration process do so in a timely manner.	Agreed Action: As set out within the Standards of Business Conduct Policy (section 6), Line Managers are responsible for ensuring employees are aware of the requirement to follow and comply with the Policy and Standards of Behaviour Framework. The Standards of Business Conduct Policy is to be discussed at Individual Performance Reviews, Consultant Appraisals and as part of the Consultant Job Plan Reviews as appropriate. In addition, the Corporate Governance Directorate will establish a centralised process to monitor and track the submission of declarations by all those staff required to submit a return in-line with the policy.

			Expected Evidence of Implementation: Standards of Business Conduct discussed at appraisals Centralised tracking and alerts process
		Medium Priority	Officer: Director of Corporate Governance Date: March 2026
	Theme: Policies & Procedures	Control Design	

Appendix A

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
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Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
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Intelligence Led Organisation Final Internal Audit Report February 2025

Aneurin Bevan University Health Board

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Review reference:	ABUHB-2425-22
Report status:	Final
Fieldwork commencement:	15 May 2024
Fieldwork completion:	04 December 2024
Debrief meeting:	07 January 2025
Draft report issued:	19 December 2024
Management response received:	06 & 10 February 2025
Final report issued:	10 February 2025
Auditors:	Stephen Chaney, Head of Internal Audit Martyn Lewis, Senior IM&T Audit Manager Sian Harries, IM&T Audit Manager Chris Scott, Internal Audit Manager
Executive sign-off:	Paul Solloway, Director of Digital Hannah Evans, Director of Strategy, Planning & Partnerships
Distribution:	Lloyd Bishop, Chief Information Officer
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.

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Executive Summary

Purpose

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.

Overview

We have issued reasonable assurance on this area.

The Health Board has developed a Data, Analytics and Information Management Strategy to progress its position to become an intelligence-led organisation. The Strategy seeks to address current gaps including the absence of a single coordinated process and an oversight group for producing intelligence products, and digital literacy training and development.

The matters requiring management attention include:

- prompt approval of the Strategy;
- an actionable statement of intent regarding Data Quality would be beneficial to underpin the new Data Strategy;
- information products developed outside of Information Services should clearly state where definitions differ to the standard; and
- the proposed project to replace the current SFN tool used within the Planning division should be delivered with appropriate representation from the division to feed in their needs.

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

Report Opinion

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

Assurance summary¹

Objectives	Assurance
1 Strategy	Reasonable
2 Resources	Reasonable
3 Engagement	Reasonable
4 Data Governance	Reasonable
5 Decision-Making	Substantial
6 IMTP data integrity	Reasonable

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

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	Data, Analytics & Information Management Strategy	1	Operation	Medium
2	Data Quality Policy	4	Design	Medium
3	Information Product Definitions	4	Design	High
4	Dynamic Planning Tool Replacement	4	Operation	Medium
5	Evidencing Patient Activity Forecast Data	6	Operation	Low

1. Introduction

- 1.1 In line with the 2024/25 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board' or 'organisation') a review of the arrangements in place for the use of information and analytics was undertaken.
- 1.2 In order to become an intelligence led organisation the Health Board must transform data into intelligence.
- 1.3 Data is a collection of facts which is raw and unorganised, information is a simplistic way of bringing data together and puts the data into context and intelligence is knowledge or insights derived from information through analysis, synthesis and interpretation.
- 1.4 The potential risk considered as part of this review were as follows:
 - there is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.

2. Detailed Audit Findings

Objective 1: Strategy – an appropriate strategy should be in place to enable the organisation to become an intelligence-led organisation and to improve the coordination and use of its data to enable cross referencing and prevention of silos.

- 2.1 The Health Board's Digital Strategy: *Transformation Through Digital* sets out the aim of enabling people to manage their health and care needs independently wherever possible, and their staff to deliver holistic care and high-quality services, through the most innovative digital solutions available. One of the core themes to be focussed on to realise this vision is *Digital Data, Information and Intelligence*.
- 2.2 The Health Board's Integrated Medium-Term Plan (IMTP) 2022 – 2025 recognises that three core elements are required to become an intelligence-led organisation:
 - quality input of data through digital platforms;
 - effective standards and management of information; and
 - the ability to turn data into intelligence for the organisation.
- 2.3 The IMTP identifies *Digital Data, Information and Intelligence* as a key enabler and is underpinned by the Digital Strategy which provides the framework for setting out the areas for delivery. The development of *Digital Data, Information & Intelligence* is articulated throughout the IMTP, in the context of resetting baselines, developing minimum data sets, shaping of priorities and the delivery framework.
- 2.4 Whilst we positively note that a *Data, Analytics & Information Management Strategy (DAIMS)* has been developed, it remains unapproved several months after formal submission. The strategy sets out the principles and standards for digital data, information and intelligence development recognising the needs of stakeholders to create a coherent approach to the strategic development and use of Information for clinical and business purposes. This will include where data

comes from, how they manage it and how they want to use it. The strategy seeks to meet defined objectives to meet their vision of providing trusted data, analytical and information management services to the Health Board and provides a road map of informing future needs and developments to support real time data use.

See Matter Arising 1 at Appendix A.

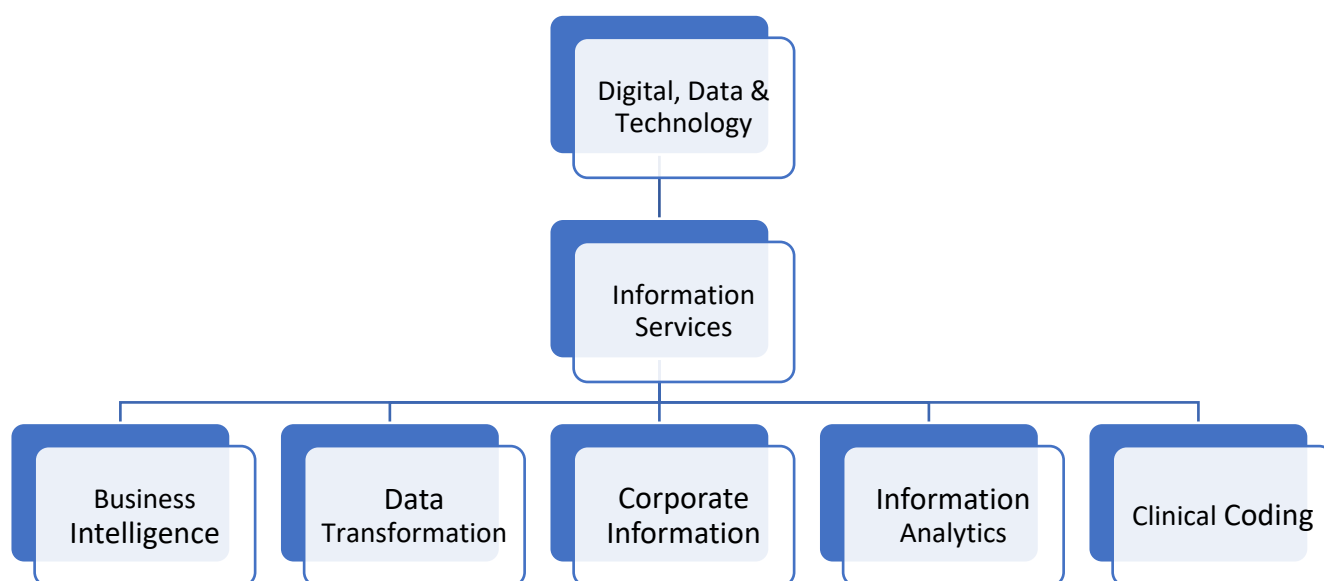
- 2.5 Our review of the draft DAIMS highlighted that the scope is organisation-wide and covers the provision of services that capture, manage and supply data in the Health Board for any corporate, clinical or operational purposes including performance monitoring and reporting. The Health Board is aware that it has multiple teams managing and supplying data in silos, which is a multifaceted issue. There is currently a lack of coordination in providing information, therefore, staff are unclear on which team to approach and will often contact more than one team simultaneously, causing a duplication of effort. Various teams utilise different methodologies and standards for analytics to that of the Information Services department and therefore, outputs may present different views to those formally reported within the organisation. This fragmentation can lead to inefficiencies, missed critical insights, and failure to leverage the full potential of their combined expertise. The DAIMS seeks to address the issue of siloed working by proposal of a centralised oversight group to provide clarity over data standards and ways of working, and to foster a culture of collaboration and shared deliverables.

Conclusion:

- 2.6 Our review of the current and proposed strategies highlighted that there is a clear framework to serve as the foundation for becoming an intelligence-led organisation, however, the DAIMS remains unapproved several months after formal submission, therefore, we have concluded **reasonable** assurance for this objective.

Objective 2: Resources – the Health Board should have sufficient resources to support an intelligence function, including financial and staff numbers and skills and tools and technologies. The Health Board should identify the most appropriate tools and technologies to fit their current and future needs. These tools should enable the organisation to acquire, process, analyse, and use data from sources that produce increasing amounts of structured and unstructured data.

- 2.7 The Health Board has an Information Services department that sits within the wider Digital, Data & Technology structure. The service consists of five teams as depicted below, which cover different functions.



- 2.8 The Business Intelligence Department is responsible for collecting, analysing, and interpreting data to support decision-making processes within the organisation. The department utilises advanced analytics tools and techniques to generate reports, dashboards, and visualisations that enable stakeholders to understand trends, identify areas for improvement, and make informed decisions.
- 2.9 The Data Transformation team works in conjunction with the Corporate Information and Business Intelligence teams to review and enrich data quality and works collaboratively with all services to advise on best practice for recording data on the Welsh Patient Administration System (WPAS) including setting up new services/sub-specialities.
- 2.10 The Corporate Information team is responsible for collating and submitting many of the mandated national reports and submissions sent to external stakeholders, including Digital Health and Care Wales (DHCW) and Welsh Government (WG). The team also produces reports for internal services and works collaboratively with service users to understand their requirements for data capture and reporting as well as ensuring compliance against data standards and the NHS Wales data dictionary.
- 2.11 The Information Analytics team provides bespoke data analysis such as demand and capacity forecasting and provides business partnering to all services to understand their needs and requirements to develop information products and solutions to help drive organisational objectives.
- 2.12 The main tools and technologies used within Information Services are:
- Data warehouse based on SQL Server;
 - Microsoft Office 365 suite, including Excel and PowerPoint;
 - Power BI;
 - Python;
 - Qlik Sense;
 - R; and
 - Simul8.

- 2.13 The main tool used by Information Services to present information and develop dashboards is Qlik Sense. All insights generated by Qlik Sense are derived using national data standards and methodologies and align with the Health Board's reported position where applicable.
- 2.14 Our review has highlighted that there is an increasing demand from across the Health Board for information products which often surpasses the capacity to deliver quickly. This can result in requestors frequently approaching other analysts within the organisation to provide required information.
- 2.15 Information Services has conducted an analysis of job titles within the Health Board, which suggests that the vast majority of employees with the word *analyst*, *data* or *information* in their job title do not sit under Information Services. Consequently, there is a lack of clarity over the full resource in place and what is being delivered across the Health Board, therefore, there is no holistic coordination of information resources. We note that other analytical tools such as Power BI and Lightfoot Solutions' signalsfromnoise (sfn) platform are used within other departments, the outputs from which may differ to the reported position due to varying analytical methodologies used to define and interrogate data sets. Further details of our review of this area can be found under Objective 4: Data Governance.
- 2.16 It is noteworthy that a Mathematical Modelling team is in place that currently sits within the Planning department. The team uses statistical and modelling concepts and techniques to better aid analysis, planning, and decision making for the organisation. These fragmented teams operate without reference to Information Services, therefore, there is little coordination of work which can lead to bottlenecks, duplications, inefficiencies and incohesive work environments. This has been identified within the DAIMS as an area of focus, and as noted under objective 1, there is a proposal to establish a central oversight group to expedite the breakdown of silos and to develop cross-functional ways of working. Consequently, we have not raised a finding in relation to this matter.
- 2.17 Information Services have started to explore forecasting and predictive analytics through the use of *Facebook Prophet*, which is an open-source Python machine learning-based tool which offers automatic forecasting of time series data. We understand from discussions held with Senior Management, that whilst appropriate skillsets are in place to develop these intelligence products, including advanced skills such as Large Language Model (LLM) and Natural Language Processing (NLP), there is limited capacity to explore and progress in newer areas such as Artificial Intelligence (AI).
- 2.18 As part of the development of the DAIMS, the Health Board has undertaken a Data Maturity Assessment which identifies the current maturity level of each of the following domains: Data, Uses, Analysis, Leadership, Culture, Tools and Skills. The assessment provides benchmark indicators based on outcomes of similar organisations' results and whilst the Health Board has scored below all but one indicator, the imminent Strategy seeks to address gaps and improve on current position and provides detailed actions to increase maturity levels across all

domains. As the Strategy remains in draft at the time of fieldwork, we have not included full details of the assessment in our report.

- 2.19 The National Data Resource / Local Data Resource (NDR/LDR) programme is also improving the use of technology for collating data and delivering intelligence. We positively note that the Health Board has a dedicated NDR team in place that reports to the Head of Enterprise Architecture to take this work forward. The *Annual Plan 2024-27: Three-year Intent* was presented to the Board in March 2024, and outlines that in Q4 2024/25 the NDR analytical tooling e.g. Google Healthcare Data Engine will commence development, and following preparatory work throughout the year data dashboards exploiting the NDR will be developed starting with an emergency department dashboard and admitted patient data. These milestones are linked to one of the key enablers, *Digital data, information and intelligence*, within the Digital Strategy and IMTP.
- 2.20 To date the wider software development teams together with the NDR team have been working on implementing the Fast Healthcare Interoperability Resources (FHIR) standard, which is the global standard for passing healthcare data between systems, through the use of *Firely*, which is a FHIR-native solution.

Conclusion:

- 2.21 Our review has highlighted that there are a number of staff across the Health Board that manage and supply data in isolation from the Information Services teams. Currently there is a lack of clarity and coordination of the total available resource in the organisation and all Information Services teams are at full capacity to fulfil the current demand for information products, which allows for limited improvement and development work. We note that this is recognised within the DAIMS, and it aims to unify the silos and enable cross-functional optimisation through the establishment of a central oversight group. Consequently, we have concluded **reasonable** assurance for this objective.

Objective 3: Engagement – a process should be in place for identifying key stakeholders (internal and external) and their requirements and translating these into deliverable intelligence products.

- 2.22 Information Services provide information to both internal and external stakeholders as noted under objective 2. We positively note that the DAIMS was informed through extensive stakeholder engagement, which provided insight into stakeholders' development needs, frustrations and aspirations such as service provision requirements, current data, analytics and information management service weak points and where focus to meet stakeholder requirements is needed.
- 2.23 Information Services has adopted a Digital Business Partner approach, whereby an analyst will work closely with a division to understand operational challenges and inform a digital mindset and also acts as a trusted advisor for digital and business change. The Business Partner keeps abreast of changes by actively participating in divisional meetings, delving into data perspectives, and understanding the areas they are keen on exploring for improved value and efficiency. The role also includes offering guidance on available data, outlining potential actions and collaborating

with divisions on intelligence development. The Business Partner is an important 'bridge' between Information Services and the service divisions, ensuring a proactive approach to addressing needs and proposing solutions based on available resources.

- 2.24 Since April 2024, the Health Board has been utilising *Halo ITSM* to manage requests for intelligence products, which is an IT Service Management solution that enables IT teams to deliver services in a standard, efficient, and ITIL-compliant manner.
- 2.25 Halo is monitored by a member of staff from each of the Business Intelligence, Corporate Information and Data Transformation Teams. Requests are fully assessed and those identified as business as usual (BAU), such as information requests, are categorised as such and worked through. The team will contact the requestor to acknowledge their request and to advise that the turnaround time for BAU requests is 14 days. All e-mails are exchanged within Halo, ensuring full visibility of requests and responses.
- 2.26 Requests identified as more complex, such as new Qlik applications, are discussed and prioritised at the weekly Senior Team meeting. The prioritisation process is multifactorial and is based on the seniority of the requestor, its urgency, the benefit to the organisation and the ease of the request.
- 2.27 Often initial requests do not contain the detailed specification requirements needed to create or develop a new information product. The team will liaise with the requestor to fully understand their needs and to gather the required detail to develop a specification document. Following prioritisation, they will inform them of the turnaround time. A prototype will be developed and following a process of incremental testing and development, the final product will be published and released under the relevant stream in Qlik Sense, with access being controlled via the Active Directory. Whilst users are able to view available information products within the streams they have access to, currently there is no global catalogue of available information products. We note that the DAIMS seeks to address this with an action to provide a catalogue of services that describes the information that is available for analysis, therefore, we have not raised a matter arising.

Conclusion:

- 2.28 Information Services are fully aware of their internal and external stakeholders and a variety of information products are provided dependent on needs and in a controlled manner. The Health Board has recently implemented the Halo system to better manage requests for information, which allows for greater oversight. A good engagement process is in place by means of the business partner approach to link in with services and to develop information products through evidenced liaison. However, as there are currently multiple teams producing fragmented outputs, it is unclear what, if any, processes are in place to develop intelligence products. Consequently, we have concluded **reasonable** assurance for this objective.

Objective 4: Data Governance – appropriate data governance management arrangements should be in place, including a policy with clearly defined roles and responsibilities, a framework for data sharing and adequate controls for all systems of data collection. The Health Board should be aware of where its data is and how it is aggregated and shared. Appropriate data governance should be in place to ensure that information remains accurate, consistent, timely and accessible. This should include metadata (i.e., data about data) management, security, privacy, data integration, data quality, and master data management.

- 2.29 Information refers to all forms of information obtained, recorded or processed by the Health Board, including personal data. Intelligence can be defined as information that has been subject to a clear evaluation and risk assessment process in order to support decision making. In addition to being evaluated, information should be analysed. Analysis involves identifying critical links and correlations that assist in understanding patterns in healthcare provision and delivery, and problems occurring/likely to occur in services. Moreover, only good quality data can power accurate analysis, which in turn can drive trusted business decisions.
- 2.30 An intelligence-led organisation, by its very nature, relies on good quality information. Capabilities must be built which enable information to be gathered, recorded, evaluated, disseminated, retained and disclosed as necessary from a range of available information sources in ways which are clear as to their potential relevance and use. It also requires the Health Board to consider how and why it collects information and to identify ways to convert this information into intelligence.

Data Governance Framework

- 2.31 Whilst the All-Wales Information Governance Policy adopted by the Health Board sets out the expectation of the need for and importance of good data quality, it does not describe what is meant by high-quality data nor does it define the roles and responsibilities for maintaining, improving and monitoring data quality. The DAIMS seeks to address this by providing clear data management principles and a proposal to formally establish an internal governance structure for data, information and analytics with defined roles and responsibilities. Whilst we positively note that the DAIMS specifies the Health Board's commitments for managing data and information, it would be beneficial to develop a data quality policy to be disseminated to all staff that supports the implementation of these commitments to act as an actionable statement of intent that galvanises the Health Board into further action. **See Matter Arising 2 at Appendix A.**

Data Awareness

- 2.32 The Health Board has an Information Asset Register (IAR) in place in order to comply with GDPR requirements, which identifies information stores. Our review noted that whilst it is not fully complete, this is recognised by the Health Board and an adequate amount of key information has been captured including what

information is held, where it is stored, how it is secured and shared, and which systems are used within each division.

- 2.33 A process is in place to regularly review and update the IAR. A lead is assigned to each division and attends regular meetings with them to gain greater understanding of each of the services within each division. Progress reports are provided to the Head of Information Governance for onward reporting to the Finance & Performance Committee (FPC).
- 2.34 In addition, the General Managers of each division are assigned as Senior Information Asset Owners (SIAOs), and representatives of each service have been assigned as IAOs. The IAOs attend quarterly Governance and Assurance Group meetings where the IAR is discussed and updated as required. We note that work is ongoing to consider improvements to the platform for collecting and storing information to enable staff to directly input information themselves. Whilst it is not yet a full record of all organisational data for use in intelligence, the IAR provides a good foundation to build on to gain full structured awareness of all the organisation's data pools. We have not raised a matter arising as we consider the process in place to review and update the IAR to be sufficient and data captured to date as adequate, however, work should continue to identify all data pools to ensure the Health Board has a holistic view of all its data flows.

Data Standards

- 2.35 Data standards are a set of well-defined rules by which data are described, recorded and shared in order to ensure common understanding among data users and to maintain data quality (integrity, consistency, format and meaning). Data standards provide the rules by which data can be transformed and enforcing them promotes consistent results from the processes using them. The use of common terminology and consistent data formats promotes re-usability and facilitates data sharing, both within the Health Board and across NHS Wales. It facilitates more effective and efficient matching and linkage and improves data quality.
- 2.36 Information Services conform to national standards for data definition, capture, control and storage. The Health Board is aware that it holds silos of information which do not conform to the same data standards and methodologies and therefore, may present a different view of any analysis undertaken.
- 2.37 The Planning division is one of the recognised silos, and we reviewed their use of data and analytics. The division uses Lightfoot Solutions' signalsfromnoise (SFN) tool, which is a third-party dynamic planning platform to interrogate data in a different way to that of Information Services, which uses the Qlik Sense platform. Qlik Sense provides performance insights into validated data with set definitions, whilst the SFN allows the definitions to be changed or ignored for modelling purposes and scenario planning. Information outputs from SFN include charts and graphical representations of data and statistical analysis which are used to inform planning conversations with services.
- 2.38 Whilst our review into this area confirmed that the division's use of data analytics is acceptable in terms of the various techniques used to slice and visualise data for its intended purpose, we note that the outputs do not provide any indication of

where definitions may differ from the standard. This has led to confusion as outputs will differ from those produced by Information Services which may cause distrust of the information provided. **See Matter Arising 3 at Appendix A.**

- 2.39 We further positively note that an action has been identified within the DAIMS to deliver a project to replace SFN with a product that meets the Health Board's planning information needs. We noted that the division is able to offer valuable insights through the use of a dynamic tool, therefore, it is important that this project is delivered without delay, and that the division is appropriately represented to fully feed in their needs and rationale for flexing definitions. **See Matter Arising 4 at Appendix A.**
- 2.40 A robust data governance structure is key for intelligence success. We note that there is currently no formally established internal governance structure for data, analytics and information and therefore, a lack of central oversight and coordination of how standards and definitions are used within various divisions. We positively note that this is recognised within the DAIMS, and actions have been identified to establish a single coordinated forum to provide guidance on national and local standards, including presentational standards. Actions have also been identified to establish a full governance structure, inclusive of a Data Strategy Delivery Group to drive forward the implementation and to ensure that all actions are delivered. The Health Board has considered its current governance position and actions within the delivery plan seek to address the current gaps, therefore, we have not raised a matter arising.

Data Warehouse

- 2.41 The Health Board's data warehouse is managed by Information Services and is based on an SQL Server database. It was upgraded in April 2023 following a review of data usage and anticipated future data requirements. Data is extracted from source systems, loaded into the warehouse and transformed to create standardised data for use complete with metadata.
- 2.42 A bespoke data quality validation tool is in place which targets specific data quality issues and writes them into a log and our review noted that there were multiple historical pending queries that had not been corrected. We established that the tool had originally been developed with the intent that services would check the logs and correct identified issues, however, due to a lack of engagement it is now used as an internal tool by the Data Transformation team to run reports identifying data quality issues to send to divisional team leaders to correct. As noted previously, the absence of a data quality policy and statement of intent means that staff may not understand the importance of their role in ensuring data quality, and therefore, are unlikely to engage in taking corrective actions. **See Matter Arising 2 at Appendix A.**

Conclusion:

- 2.43 Our review has highlighted that whilst there is currently no formal internal governance structure for data, information and analytics, the DAIMS has identified the most important changes required to become an intelligence-led organisation and proposes an action plan to address. It would be beneficial to develop a

statement of intent around data quality to underpin the DAIMS' commitments and to ensure that all staff understand what high-quality data is and their responsibility in upholding it. The establishment of a central oversight forum to coordinate and control the use of definitions and standards across the Health Board is pivotal to provide leadership and best practices. Consequently, we have concluded **reasonable** assurance for this objective.

Objective 5: Decision Making - Intelligence products are used to inform decision making. They should follow appropriate standards and be designed with the appropriate flexibility of input parameters to allow consumers to narrow or broaden the focus of their analysis. This flexibility enables consumers to ask questions that might not have been anticipated during the initial development phase and supports adoption by empowering consumers with self-service capabilities.

- 2.44 Qlik Sense provides users with up-to-date information on a range of metrics. Qlik applications allow users to drill down to individual patient level for a clear and detailed view of performance. Dashboards and reports are tailorable and can be sliced and filtered to answer any question the user may have of the data.
- 2.45 Once information products have been developed and published, they are monitored for their use and success. Licence and log monitoring is in place to observe the most used and unused dashboards. More recently, the Health Board has established a Values & Efficiencies meeting which is currently in its evaluation stage to identify and agree measures to be tracked. The intent is to monitor performance improvement within services following development and dissemination of relevant information products to ensure that the information provided is being used appropriately to make positive changes.
- 2.46 Qlik Sense dashboards and reports are used throughout the organisation. We conducted a staff survey and whilst there was limited response, overall, it is felt that information products received are useful and reliable and mostly timely and relevant. The majority of respondents use information products to inform decision making and make changes to current activities or to monitor performance. The response did identify a demand for more intelligence as most respondents do not consider the organisation to be fully making use of its available data and state a need for better analytics and modelling.
- 2.47 We noted from the survey responses that staff may not always know which division to approach if they require an information product and it was suggested that a 'scattergun' approach is often deployed by contacting multiple teams at once, which highlights the need for a central oversight group to develop a single structured process for information as noted under objective 4.
- 2.48 In order to effectively use intelligence and information tools, users within the organisation need to be comfortable working with information and understand core concepts in relation to the data and information provided. From our discussions and survey responses we note that this is felt to be an area where skills across the organisation are lacking with gaps in data literacy and in the use of intelligence

tools. This presents a risk to the Health Board that intelligence may not be fully used, or be used inappropriately if, for example, users do not understand the difference between correlation and causation. We note from the DAIMS, that this has been fully recognised and is an area to be focussed on within its delivery plan, therefore, we have not raised a matter arising.

Conclusion:

- 2.49 Information products are used to inform decision making and the dashboards produced enable filtering and adjusting in order to tailor the information provided. We note that there is demand for greater intelligence provision, however, skills in data use and understanding vary across the organisation which could impact on the successful use of intelligence. We note that this has been fully recognised within the DAIMS and actions within its delivery plan aim to address this matter. Contingent to the successful implementation of the DAIMS, we have concluded **substantial** assurance for this objective.

Objective 6: IMTP – where data is used for IMTP modelling, an appropriate audit trail of assumptions and justification is maintained. The Health Board can demonstrate the reasoning and rationale behind a sample of data values inputted into models utilised within the IMTP. For example, demand / capacity modelling.

- 2.50 Services across the Health Board forecast expected activity demand for future years using a variety of different planning models. Typically, these are populated with data from within the Health Board (and in some cases, external systems), via a data warehouse and data is transferred into the latter from these systems on a regular basis.
- 2.51 Planning tools are sophisticated and capable of identifying and eliminating exceptional activity data (e.g. the COVID lockdown months, public holidays) from forward looking forecasts, to ensure these are not incorrectly influenced by these periods.
- 2.52 Combined with other data related to future expected demand and planned capacity of the services, the models forecast expected activity levels for the years covered in the plan. This data is then used to populate the activity forecast tables in the Health Board's IMTP.
- 2.53 Included in the forecasting model is a validation process step of comparing previous year forecast values against the actual activity volumes achieved. Variances in these are assessed and where appropriate, used to inform the derivation of future forecast figures.
- 2.54 Forecasting models are supported by assumptions, for example, about growth in demand / capacity, which provide the modelling parameters that populate the different service's planning frameworks.
- 2.55 The anticipated demand models are complex and because they are continuously updated from daily activity and will always use the data captured to the date they are run to compile a forecast, it was not possible to recreate the forecast numbers

that were generated in Spring 2024 for the 2024/25 plan year, seven months later, at the time of the audit.

- 2.56 However, we examined the process behind the build of the forecast activity data submitted in the Minimum Data Set (MDS) submission across three sample areas:
- Planned Care activity;
 - Diagnostics – Endoscopy; and
 - Cancer Care activity.

Planned Care activity

- 2.57 The Planned Care activity forecast numbers for 2024/25 were agreed from the MDS submission document to the Health Board's demand and capacity model for Outpatient appointments. Activity levels for 32 services are included in the latter category.
- 2.58 One service (Rheumatology) was selected from these and the monthly forecast numbers agreed back to the Dynamic Planner Forecast Chart that had been used to generate the forecast numbers. We noted no exceptions or anomalies in following this trail.

Diagnostics - Endoscopy

- 2.59 The forecasting model used for this service was developed by the National Endoscopy Programme (NEP).
- 2.60 We were advised that Health Board data for the model is taken from a combination of Welsh Patient Administration System (WPAS) and endoscopy (EMS) systems.
- 2.61 Health boards are required to submit their data (requests, activity and waiting list) on a monthly basis and from that information the National Programme Team populate the demand element of the forecasting model using projections provided to them by Bowel Screening Wales.
- 2.62 Health boards are sent the completed planning tool and use the forecast activity data in their annual plans.
- 2.63 Anticipated demand for endoscopy services is assessed in the planning tool, initially using a system of weighted measures based upon procedure type. These are then converted back to case numbers recorded in the MDS.
- 2.64 Exceptionally, for the March 2024 MDS submission, pro-rata values of actual activity of the 2023/24 year had been used for the forecast but the Planning team were unable to provide or replicate the material to support the values in question.

See Matter Arising 5 at Appendix A.

Cancer Care Activity

- 2.65 Cancer Care referral activity forecasts are generated in the Facebook 'Prophet' tool using data captured and extracted from the Health Board WPAS Cancer Tracker application.

- 2.66 We agreed anticipated (i) overall and (ii) GP referral figures for 2024/25 recorded on the MDS submission to the Facebook 'Prophet' planning tool calculations and in doing so noted no exceptions or anomalies.
- 2.67 For this area of activity the MDS forecast tables also include (i) 'Planned % compliance with single cancer pathways performance' and (ii) 'Planned % reduction in backlog of those patients waiting over 62 days'.
- 2.68 We were advised that the values for these elements in the MDS submission are not taken directly from data set analysis, but rather are Health Board aspirational targets for these activities.

Conclusion:

- 2.69 Services across the Health Board forecast expected demand for future years using a variety of different planning tools. These import historic patient activity data from Health Board systems and combine it with other data related to future expected demand and planned capacity. The models forecast expected activity levels for the years covered in the plan. We recorded one minor anomaly in the sample activity areas examined and have concluded **reasonable** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Data, Analytics & Information Management Strategy (Operation)		Impact	
A Data, Analytics & Information Management Strategy (DAIMS) has been developed. The Strategy sets out the principles and standards for digital data, information and intelligence development recognising the needs of stakeholders to create a coherent approach to the strategic development and use of Information for clinical and business purposes. We note however, that the strategy remains unapproved.		Potential risk of: the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.	
Recommendations		Priority	
1.1	Management should ensure that the Data, Analytics & Information Management Strategy is promptly approved and adopted to drive organisational alignment, enhance decision-making, and ensure effective use of data across all areas of the Health Board.	Medium	
Agreed Management Action		Target Date	Responsible Officer
1.1	The final engagement session has been held with the Director of Strategy, Planning & Partnerships and the Director of Public Health and the final version of strategy will be taken to the Executive Committee for formal approval in February 2025.	Feb 2025	Director of Digital

Matter Arising 2: Data Quality Policy (Design)		Impact	
Whilst the All-Wales Information Governance Policy adopted by the Health Board sets out the expectation of the need for and importance of good data quality, it does not describe what is meant by high-quality data nor does it define the roles and responsibilities for maintaining, improving and monitoring data quality. The DAIMS seeks to address this by providing clear data management principles and a proposal to formally establish an internal governance structure for data, information and analytics with defined roles and responsibilities. Whilst we positively note that the DAIMS specifies the Health Board’s commitments for managing data and information, it would be beneficial to develop a data quality policy to be disseminated to all staff that supports the implementation of these commitments to act as an actionable statement of intent that galvanises the Health Board into further action.		Potential risk of: the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.	
Recommendations		Priority	
2.1	A Data Quality Policy should be developed to underpin the commitments made within the Data, Analytics and Information Strategy and to act as an actionable statement of intent to all staff.	Medium	
Agreed Management Action		Target Date	Responsible Officer
2.1	A formal data quality policy will be developed alongside a proposal for an audit team within Digital, Data & Technology to provide assurance over implementation and compliance	May 2025	Chief Information Officer

Matter Arising 3: Information Product Definitions (Design)		Impact	
Whilst our review into the use of information and analytics within the Planning division confirmed that its use of data analytics is acceptable in terms of the various techniques used to slice and visualise data for its intended purpose, we note that the outputs do not provide any indication of where definitions may differ from the standard. This has led to confusion as outputs will differ from those produced by Information Services which may cause distrust of the information provided.		Potential risk of: the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.	
Recommendations		Priority	
3.1	Management should ensure that all information products produced outside of Information Services clearly indicate where definitions differ from the standard.	High	
Agreed Management Action		Target Date	Responsible Officer
3.1	Through the implementation of the Data & Analytics Information Management Strategy a Centre of Excellence will be established led by the Chief Information Officer to ensure outputs where relevant comply with standards and a ABUHB “kitemark” will be added to reports so this will be clearly visible	July 2025	Chief Information Officer

Matter Arising 4: Dynamic Planning Tool Replacement Project (Operation)			Impact
We note that an action has been identified within the DAIMS to deliver a project to replace SFN with a product that meets the Health Board’s planning information needs. We noted that the division is able to offer valuable insights through the use of a dynamic tool, therefore, it is important that this project is delivered, and that the division is appropriately represented to fully feed in their needs and rationale for flexing definitions.			Potential risk of: the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.
Recommendations			Priority
4.1	Management should ensure that the project to replace the SFN tool used within the Planning division is delivered, with appropriate representation from the division to fully feed in their needs.		Medium
Agreed Management Action		Target Date	Responsible Officer
4.1	A formal governance structure is in place chaired by the Director of Strategy, Planning & Partnerships and the Director of Digital. This project group contains representations from digital, planning and service leads and is managing the replacement for the SFN product.	March 2025	Director of Strategy, Planning & Partnerships / Director of Digital

Matter Arising 5: Evidencing patient activity forecast data (Operation)			Impact
We were unable to obtain source data to support the patient activity forecast numbers recorded in the Health Boards minimum data set (MDS) submission of March 2024 for one of the three sample services examined in the audit and noted that in this case, exceptionally these had been estimated from prior year activity statistics rather than through the National Endoscopy Programme activity forecasting model which is the normal method.			Potential risk of data errors in activity forecast model data.
Recommendations			Priority
5.1	Management should ensure that the source data is retained that was used to generate the entries in the Health Board’s MDS submission regardless of the model employed to generate the forecasts.		Low
Agreed Management Action		Target Date	Responsible Officer
5.1	For all MDS measures derived from the Health Board corporate data warehouse, the source data is retained and is replicable. For MDS measures derived from sources outside of the Health Board corporate data warehouse, the Planning team will implement a process to ensure that this source data is retained.	April 2025	Director of Digital

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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



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End of Life Care

Final Internal Audit Report

2024/25

Aneurin Bevan University Health Board



Reasonable Assurance

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Review Reference

ABUHB-2425-11

Fieldwork

November 2024

Executive Sign Off

December 2024

Audit Committee

February 2025

Executive Lead

Jennifer Winslade, Executive
Director of Nursing

Head of Internal Audit

Stephen Chaney

Executive Summary

Purpose

To determine if care arrangements for end-of-life (EoL) patients are planned sufficiently in advance to enable their care to be provided in the community and to avoid unnecessary hospital admission.

Overview

We have concluded **reasonable assurance** on this area, which has taken into account the points noted below. The Health Board provides a range of resources directed at facilitating advance care planning for end of life but national audits (National Audit of Care at the End of Life – NACEL) indicate a low incidence of such plans in patient records. Whilst these resources are available and their use encouraged, because planning for end of life is the choice of the patient¹, the Health Board does not prescribe or control activity in this area. As a result, excepting those few elements which direct intervention decisions which must be actioned (e.g. patient owned 'Advance Decision to Refuse Treatment', Health Board owned 'Treatment Escalation Plans') there is a lack of a documented policy and procedure over its use. We focussed on the completion of Advance Care Plans (ACP) as part of Future Care Planning arrangements and reviewed a sample of hospital admissions.

Consequently, whilst there are numerous contact points and evidence of discussions taking place with patients over care planning (e.g. DNACPR), there is no mandatory requirement for the patient to maintain an ACP. In addition, we found that viewing or determining the completion of an ACP was not always straightforward. Overall, we were unable to conclude if ACPs were completed as required, due to the lack of a mandatory framework and whilst we saw evidence of discussions / contact points in relation to end of life planning, we were unable to determine if this was fully complete. Therefore, we recommend in the first instance, that the Health Board set out the standards of documentation and the level of completion required for each EoL patient, including discussions and contact that takes place.

NACEL audits report on a wide range of aspects of care provided to patients at end of life and, as national reviews, allow health boards to compare their practices with other health care organisations. Recommendations from the latest audit (2022) included improvements to aspects of advance care planning and were published in mid-2023. The Health Board has acknowledged these issues in an action plan but had not addressed them at the time of this audit.

Our review of practices and related documentation protocols for End of Life patients was limited to advance care planning in the acute hospital setting.

The matters requiring management attention are:

- a framework for the capture and management of patient Future Care Planning documentation; and
- addressing the findings of the 2022 (NACEL) audit relating to advance care planning.

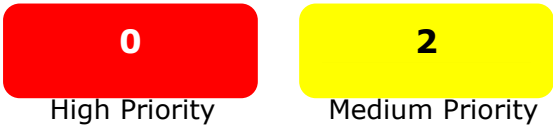
Full details of matters arising are detailed within the Findings & Agreed Action Plan.

¹ Not everyone will want to make an advance care plan, but it may be especially relevant for: People at risk of losing mental capacity – for example, through progressive illness. People whose mental capacity varies at different times – for example, through mental illness. Source: NICE [advance-care-planning-quick-guide.pdf](#)

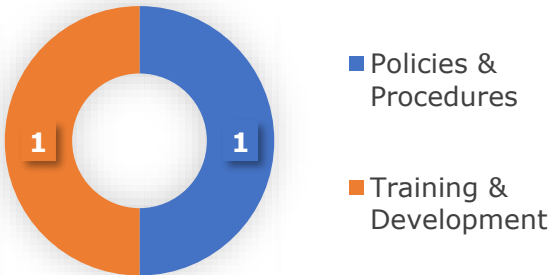
Scope & Assurance Summary

Objectives	Related Findings	Assurance
1 There are processes for planning ahead for a patient’s death and then for carrying out that plan	1, 2	Reasonable
2 Where circumstances permit and it is the wish of the patient, end of life care is provided in the community (patient’s home, hospice care, care home) rather than in hospital		Reasonable

Management Actions



Themes



Risk Types

Public Perception & Reputational Risk
Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: There are processes for planning ahead for a patient’s death and then for carrying out that plan

Reasonable

Overview / Summary of Observations

The Health Board provides guidance on future (formerly termed ‘advance’) care planning (FCP) to patients via a number of routes. A wide variety of resources are available for individuals to record their wishes and preferences for care when they are nearing end of life. However, recent national studies (NACEL, fourth round, 2022) indicate a low incidence of advance care planning for end-of-life patients before being admitted to hospital, (24% for acute admissions, 17% for community hospital). The process of patient FCP is voluntary, and it is the responsibility of the individual to ensure that they keep any record of wishes up to date and that all who may need a copy of their record have one. The Advance Decision to Refuse Treatment is of particular importance as it is legally binding and must take precedence over decisions made in the patient’s best interest by other people.

We noted there are initiatives underway to introduce electronic forms to capture some elements of FCP. However, at present there is an absence of a formal framework within the Health Board to reliably and consistently promote and facilitate the central capture and recording of a patient’s end-of-life wishes. [MA1].

We noted also that recommendations to address the low incidence of advance care plans in the records of end-of-life patients (and other findings) in the 2022 NACEL audit had not been addressed by the Health Board at the time of this audit. It is likely that the development of a formal framework would assist in the completion of the actions. [MA2].

Key Findings		Risk & Impact	Agreed Management Action
1	<i>Framework for the capture and management of patient Future Care Planning documentation</i> Whilst we appreciate that it is the responsibility of the individual to share FCP documents with the necessary health care providers (Health Board, GP, OOH GP, Ambulance Service, District Nursing service etc.) there is an absence of a policy within the Health Board and / or a supporting procedure to cover the: capture; coordination; and management of these key documents.	Risk that patient’s future care planning wishes, preferences and directives may be overlooked and not met.	Agreed Action: The Health Board are working towards implementing a robust framework for capturing and managing patient Future Care Planning (FCP) documentation. This will include the following elements: Identification and Targeting: Implement a structured approach to identify patients who would benefit from FCP, such as those with chronic illnesses, frailty, or nearing end-of-life. Tools like the Elderly Risk Assessment score can be useful Standardised Documentation: Use standardised forms and templates to ensure consistency in FCP documentation. This can include advance directives, anticipatory clinical management plans, and patient preferences for care

			Multidisciplinary Collaboration: Encourage daily multidisciplinary huddles to discuss and document FCP for identified patients. This ensures that all relevant healthcare professionals are involved in the planning process Electronic Health Records (EHR) Integration: Transition to digital ACP plans for better accessibility and efficiency. Integrate FCP documentation into the EHR system to ensure accessibility and continuity of care. This allows for easy sharing and updating of patient care plans across different care settings Education and Training: Provide ongoing education and training for healthcare professionals on the importance of FCP and how to conduct and document these conversations effectively. Establish and expand the role of ACP Practice Educators to provide specialised training and support. Increase the number of Advance Care Planning (ACP) facilitators to ensure better support in secondary care settings. Patient and Family Involvement: Ensure that patients and their families are central to the FCP process, with personalised conversations focused on their values and preference.
			Expected Evidence of Implementation: Implementation of the above actions and FCP documentation referenced above, including a Framework, updated FCP documentation (forms and templates), including the use of digital ACP plans and evidence of ongoing training.
			Medium Priority Officer: Director of Nursing Date: Implementation dates to be determined by the End of Life Board, which will be completed by the 30th April 2025. An updated implementation schedule will be provided following this process.
Theme: Policies & Procedures	Control Design		

2	<i>Addressing the findings of the 2022 NACEL audit</i> We noted that recommendations from the 2022 NACEL audit published in July 2023 in respect of advance care planning improvement had been noted by the Health Board and whilst, captured in an action plan of the End of Life Care Board, had not at the time of this audit (Q3 2024/25) been addressed.	Risk that where there are opportunities to avoid patient hospital admission at end of life these opportunities are missed.	Agreed Action: The Health Board will address the 2022 National Audit of Care at the End of Life (NACEL) with an updated improvement plan. This will focus on the highlighted areas for improvement in end-of-life care: Quality of Care: The audit emphasised the need for better quality and outcomes of care for dying patients and their families. This includes ensuring that care is aligned with patient preferences and values, as aligned to the FCP. Documentation and Communication: Improve the documentation of advance care planning (now FCP) and communication with patients and families about their care preferences Staff Training and Support: The audit identified the need for enhanced training and support for healthcare staff to improve their confidence and competence in delivering end-of-life care Patient and Family Feedback: Incorporating feedback from patients and families into care planning and quality improvement initiatives was highlighted as a crucial area for development and will be discussed at Board.
		Medium Priority	Expected Evidence of Implementation: Updated NACEL audit and evidence as detailed within finding one, including an updated Framework, documentation and ongoing training.
	Theme: Training & Development	Control Operation	Officer: Director of Nursing Date: Implementation dates to be determined by the End of Life Board, which will be completed by the 30th April 2025. An updated implementation schedule will be provided following this process.

Objective 2: Where circumstances permit and it is the wish of the patient, end of life care is provided in the community (patient's home, hospice care, care home) rather than in hospital

Reasonable

Overview / Summary of Observations

We noted in the previous section the low incidence of patients' recording their end of life preferences in advance in a documented FCP. NACEL examined a sample of deaths that took place in acute and community hospitals and whilst they provide no data on patient preferences, we noted that they do record in a quality survey, conducted as part of the study that in a high proportion of the cases examined, that in the circumstances, the hospital was the right place for the person to die.

We were advised separately that where patients at end of life require CHC support for discharge to return home for their last days, this is always made available.

We were unable to obtain data of patients identified as at end of life in their own home, care home or hospice who were admitted to hospital, acute or community, against their preference and consequently, there are no findings under this objective. However, as we were unable to test against the whole objective, we have provided reasonable assurance.

Appendix A

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	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.
	Advisory	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 Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

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Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.



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

Date issued: February 2025

Document reference: 3997A2024

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

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About this document

- 1 This document provides the Audit, Risk and Assurance Committee with an update on our current and planned accounts and performance audit work at Aneurin Bevan University Health Board.
- 2 We also provide additional information on:
 - Other relevant examinations and studies published by the Audit General.
 - Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.
- 3 Details of future and past Good Practice Exchange (GPX) events are available on our [website](#).

Accounts audit update

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

Exhibit 1 – Accounts audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Audit of 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.	Audit complete, pending certification	29 Jan 2025 Board meeting
Audit of Accounts 2024-25	Rob Holcombe – Director of Finance and Procurement	We will follow the audit approach designed as part of our planning work and undertake appropriate audit testing to enable to Auditor General to provide his opinions on the financial statements of the Health Board.	Planning	June 2025 ARAC & Board, dates yet to be confirmed

Performance audit update

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

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment – Deep dive on financial efficiencies	Chief Executive Officer	In addition to the core structured assessment work, we will also undertake “deeper dive” work in a specific area. We had initially identified digital transformation as the deeper dive topic for 2023. However, given the financial challenges facing the NHS at present, we are looking to now focus our deep dive work in health boards on financial savings / cost improvement plans.	Final	This Committee

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment 2024 - Core	Chief Executive Officer	Our structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2024 Structured Assessment will review: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and Corporate financial planning and management arrangements.	Final	This Committee

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Urgent and Emergency Care	Chief Operating Officer	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. The work will include an examination of the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow (Part 1). We also plan to review progress being made in managing unscheduled care demand by helping patients access services which are most appropriate for their unscheduled care needs (Part 2).	Phase 1 Flow out of Hospital Part a – Clearance Part b - Final Phase 2 Managing Urgent and Emergency care – internal clearance	April 2025

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Quality Governance Review Follow up (Local Work)	Executive Director of Nursing Medical Director Executive Director of Therapies and Health Sciences	The work will assess the extent to which previous audit recommendations arising from our thematic review of Quality Governance arrangements have been implemented and are delivering the intended outcomes / benefits. It will also focus on the Health Board's preparedness for the Duty of Quality and Candour and the effectiveness of its governance arrangements in providing assurance over its compliance.	Report Drafting	April 2025
All-Wales thematic review of planned care	Chief Operating Officer	This work will follow on from the national <u>report on tackling the planned care backlog</u>. Whilst the exact focus of this work is still to be determined, it is likely to consider: • The extent that health boards have achieved Welsh Government targets for recovering planned care services; • The efficacy of local plans and activity to recover waiting lists; and • Use of the additional Welsh Government financial allocations to improve waiting lists.	Fieldwork in progress	April 2025

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Eye Care Review (Local Work)	Chief Operating Officer	The precise focus of this work is still to be determined but will look to assess the Health Board's eye care services to ensure they are delivered efficiently, effectively, and economically, and there are clear plans to meet current and future population needs.	Fieldwork	April 2025
Structured Assessment 2024 Deep Dive - Review of investment in digital systems	Chief Executive Officer	This review will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.	Scoping	To be confirmed

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. We will be bringing the Cancer Services in Wales report to the Committee for presentation once a response to the recommendations has been received from Welh Government.

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

Title	Publication Date
<u>Cancer Services in Wales</u>	January 2025
<u>National Fraud Initiative Self-Assessment Template</u>	December 2024
<u>The National Fraud Initiative in Wales 2022-23</u>	October 2024
<u>Welsh Language Report 2023-24</u>	September 2024
<u>Active Travel</u>	September 2024
<u>Affordable Housing</u>	September 2024

Additional information

7 **Exhibit 4** provides information on corporate documents published by Audit Wales. The reports highlighted in bold have been published since the last committee update. Links to the documents on our website are provided. There are no relevant Audit Wales consultations currently underway.

Exhibit 4 – Audit Wales corporate documents

Title	Publication Date
<u>Fee Scheme 2025-26</u>	January 2025
<u>Audit Quality Report 2024: Strengthening Trust in Audit</u>	January 2025
<u>Equality Report 2023-24</u>	November 2024
<u>Estimate of Income and Expenses for Audit Wales for the year ended 31 March 2026</u>	November 2024
<u>Interim Report 2024-25</u>	October 2024
<u>Welsh Language Report 2023-24</u>	September 2024
<u>Annual Report and Accounts 2023/24</u>	August 2024



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Rydym yn croesawu gohebiaeth a
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Review of Cost Savings Arrangements – Aneurin Bevan University Health Board

Audit year: 2023

Date issued: December 2024

Document reference: 4648A2024

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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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Introduction

- 1 NHS Wales is facing unprecedented financial challenges. The legacy of the COVID-19 pandemic on service demand, the rising costs associated with staffing, energy, medicines, maintaining an ageing estate; and tackling the increasingly complex health conditions associated with an ageing population all contribute to the worsening financial situation across the NHS.
- 2 Despite the Welsh Government making an additional £425 million available to the NHS in October 2023, the 2023-24 year-end audited position for NHS Wales was a collective deficit of £183 million. Whilst some NHS bodies were able to achieve year-end financial balance, the position for others - particularly some Health Boards - was challenging with several not being able to deliver the control total deficit expected by Welsh Government.
- 3 The position for 2024-25 is equally, if not more challenging. Health bodies will need to ensure that they have robust approaches in place to identify and deliver in year cost improvement opportunities and to also take a longer-term approach to achieving financial sustainability that moves away from short-term approaches to ones where savings are achieved by transforming service models and ways of working.

Objectives and scope our work

- 4 Given the challenges outlined above, the Auditor General has undertaken a programme of work examining NHS bodies' approaches to identifying, delivering, and monitoring sustainable cost savings opportunities. Whilst our more detailed work has been targeted at health boards, we have also undertaken high level work at Special Health Authorities and NHS Trusts, linked to the specific functions of those bodies. The findings from our work at Aneurin Bevan University Health Board (the Board) are set out in this report.
- 5 The work has been undertaken to discharge the Auditor General's statutory duty under Section 61 of the Public Audit (Wales) Act 2004 to be satisfied that the Trust has proper arrangements in place to secure economy, efficiency, and effectiveness in its use of resources.
- 6 This review builds on our 2022 Review of Efficiency Savings Arrangements that included nine recommendations. Those recommendations have now been superseded by the recommendations from this current review as detailed in **Exhibit 2**.
- 7 We undertook our work between February 2024 and May 2024. The methods we used to deliver our work are summarised in **Appendix 1**.

Key findings

- 8 Overall, we found that **whilst the Health Board did not achieve its deficit control total or savings target for 2023-24, it delivered significantly more savings than in prior years. However, its financial position remains very challenging. As a result, it urgently needs to develop a longer-term financial plan focused on achieving recurrent savings from transformational service change, and further embed its savings approach through its Value and Sustainability Board to strengthen its savings arrangements and prevent its financial position from deteriorating further.**
- 9 The findings that support our overall conclusion are summarised below under the following headings:
- Identifying cost improvement opportunities.
 - Delivering cost improvement opportunities.
 - Monitoring and overseeing cost improvement opportunities.

Identifying cost improvement opportunities

- 10 The Health Board has clear arrangements in place for identifying and analysing the areas that are driving its costs in the short- to medium-term, namely variable pay (agency, bank, and locum), Continuing Health Care, prescribing, energy, delayed transfers of care, growth in demand for Cancer services, provision of SAFE services, and more general demand and capacity challenges. Despite this, the Health Board failed to meet its deficit control target of £13 million for 2023-24, instead reporting a year-end outturn deficit of £49.8 million. These high-cost areas continued to be the key contributors to the Health Board's significant reported opening underlying deficit of £81.4 million for 2024-25.
- 11 The Health Board's Annual Plan for 2024-25 forecasts a £48.9 million deficit, which is £36.9 million higher than Welsh Government's agreed control deficit total. However, as at the end of August 2024, the Health Board was forecasting an overall in-year deficit of £47.9 million, which is a £1 million improvement against its submitted plan. Given these significant financial challenges, the Health Board is developing a three-year recovery plan as part of an agreed route map to sustainability (see **paragraph 19**). Whilst this is positive, the Health Board also needs to develop robust longer-term financial plans (alongside its long-term organisational and clinical strategies) to provide assurance that it has a clear framework in plan for identifying, mitigating, and managing its significant cost drivers beyond 2026-27. **(Please refer to the recommendation on long term financial planning in our 2024 Structured Assessment Report)**
- 12 The Health Board uses evidence from a wide range of data sources to analyse and identify savings opportunities. This is a key element of the work of the Health Board's Value and Sustainability Board, which meets fortnightly to consider progress across defined savings workstreams (such as workforce, medicines

management, and service redesign) using data from CHKS¹, VAULT², GIRFT³ reviews, and audits. The identified opportunities are captured within the Health Board's Compendium⁴, which provides a central repository for identifying and monitoring progress on both national and local savings opportunities. However, the opportunities identified in the Compendium are largely focused on delivering savings in the short-term rather than longer-term savings that have been identified from transformational service change within the Health Board. Furthermore, the Compendium has not been fully utilised across all areas of the Health Board. Additional work is therefore needed to ensure that all service areas utilise and realise the full potential benefits of the Compendium. **(Recommendation 1)**

- 13 Although the Health Board has a defined approach in place for canvassing, capturing, and assessing cost savings opportunities and best practice from staff, it is not clear to what extent these ideas and suggestions then become fully formed savings schemes. Also, the extent to which the Health Board routinely canvasses savings suggestions and ideas from service users and other stakeholders is unclear. **(Recommendation 2.1 and 2.2)**
- 14 The Health Board's Value and Sustainability Board provides oversight of the organisation's arrangements for identifying and assessing the quality implications of savings schemes. The level of detail required for the quality impact assessment is dependent on the scale of the scheme and its likely impact on patients, Health Board objectives, and partners. The Health Board is also developing other mechanisms to assess impact, risks, and benefits for savings schemes that require investment, such as its Pre-Investment Panel. Despite these defined processes, there is an inconsistency in the extent to which they have been routinely applied across all identified savings schemes. **(Recommendation 3)**

Delivery of cost improvement opportunities

- 15 As shown in **Exhibit 1**, the Health Board has a variable track record of achieving its overall and recurrent savings targets. Whilst the Health Board delivered significantly more savings in 2023-24 than it had delivered in prior years, delivery of overall savings, and in particular recurrent savings, continues to present a challenge and impacts on the Health Board's ability to meet its required year-end position. **(Recommendation 1)**

¹ CHKS - Caspe Knowledge HealthCare Systems is a provider of healthcare intelligence, benchmarking, and quality improvement services.

² VAULT - The Value, Allocation, Utilisation and Learning Toolkit is managed by the NHS Executive to support and improve resource utilisation across the Welsh NHS.

³ GiRFT - Getting it Right First Time are programmes designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change.

⁴ Compendium - Is the Health Board's repository for savings and efficiency ideas and initiatives, drawn from a wide variety of sources.

Exhibit 1 – Health Board’s savings track-record between 2018 and 2024

Year	Overall Savings Target £(M)	Actual overall savings delivered (£M)	Recurrent savings as a % of overall savings target	Delivered non-recurrent savings (£M)	Delivered recurrent savings (£M)
2018-19	28	28	64.3%	10	18
2019-20	16.8	15.5	56.5%	6	9.5
2020-21	33	9.5	25%	1.2	8.3
2021-22	16.6	16.5	66%	5.5	11
2022-23	26.2	23	19%	18	5
2023-24	51.5	43	54.3%	15	28

Source: Welsh Government Monthly Monitoring Returns and Health Board Finance Reports.

- 16 The Health Board’s position on the delivery of savings in 2023-24 would have been significantly worse than reported if it had updated its overall savings target to reflect Welsh Government’s additional 10% savings requirement of £11.3 million⁵ and the additional deficit of £33 million identified as part of its mid-year review of the 2023-24 Annual Plan. Whilst the Health Board reported the need to deliver additional savings to meet the additional 10% requirement in overall terms and address the increased mid-year underlying deficit, it did not amend its original savings target of £51.5 million to reflect these additional elements. As a result, this was not part of its routine reporting on savings to the Board and the Finance and

⁵ Welsh Government’s additional 10% savings requirement of £11.3 million was set to deliver the control total deficit of £13 million. It was based on the Health Board’s original 2023-24 Annual Plan which forecast a deficit of £112 million and not the £145 million deficit forecast as part of the Health Board’s mid-year review.

Performance Committee (F&PC). Incorporating the additional savings target would have provided a more accurate picture of the overall savings required for 2023-24, resulting in a savings target of £96 million and a reduction in the percentage of recurrent savings delivered, from 54.3% to 30%. **(Recommendation 4)**

- 17 The Health Board's savings planning is primarily focused around its annual planning process. As part of its 2023-24 budgetary control procedures, those with divisional and directorate budgetary responsibilities formally received their savings targets through the Delegation Letter, which required them to deliver savings through a mix of generic, specific, focused and stretch savings⁶. For 2024-25, the Health Board has used a two-part budget setting process. The first stage involved an initial delegation of the approved levels to divisions and directorates, followed by a second delegation during quarter 1 as part of finalising the financial savings and cost pressure plans for the year. The second stage of the budget setting process was due to take place in the second quarter of 2024-25 and aimed at ensuring the delegated savings targets are based on more robust information.
- 18 In August 2024, Internal Audit provided a reasonable overall assurance rating on the Health Board's arrangements for savings planning. Despite this relatively positive position, the Health Board's financial position for 2024-25 and beyond remains challenging in terms of savings delivery.
- 19 The Health Board has made some positive initial steps to develop a short-medium term financial plan. In July 2024, it approved a three-year route map which aims to achieve its £13 million control total by 2025-26 and deliver financial balance by 2026-27. The plan will focus on key opportunities areas such as workforce, estates, service reconfiguration, and efficiencies / improvements in productivity. The Health Board's financial route map will need to be routinely refreshed to ensure it reflects internal and external risks and remains current. At the time of our review, the granular 'delivery plan' and financial details within the route map were still being developed. **(Recommendation 5)**
- 20 The Health Board has invested in developing financial skills and capabilities to support its savings delivery; however, aspects of its financial capabilities need to be further improved. The role of Financial Business Partners⁷ to support directorates and divisions around savings planning and delivery is highly regarded by senior officers. However, despite investment in developing some general online financial training tools, there is scope to increase finance training for managers and leaders. **(Recommendation 6)**

⁶ Delegation Letter 2023/24 – (a) generic savings target of 0.75% for executive areas and 0.5% for other areas; (b) specific savings plans have been applied where there is reasonable expectation of delivery; (c) focussed opportunities where there is an indication that savings could be made but further work is required; and (d) stretch targets where applicable these include areas of spend slippage and possible funding.

⁷ Financial Business Partner is a role that has responsibility for working with divisions and directorates team providing financial support and information to support planning and operational management.

Monitoring and oversight of cost improvement opportunities

- 21 The Health Board has well-developed arrangements in place for monitoring the delivery of savings. The finance reports, which form the basis of its savings reporting, provide both a summary of progress against the key cost drivers and granular detail on savings performance across the divisions and directorates within in the report's appendices. This level of detail enables the Board, the Value and Sustainability Board, and F&PC to both understand overall savings progress and, if necessary, scrutinise progress on savings delivery at a more granular level.
- 22 The Health Board has a relatively new internal accountabilities framework in place which is designed to allow the Executive Team to hold directorates and divisions to account for their service and financial performance. However, the framework does not yet appear to fully effective, as some areas (such as Corporate Services and Scheduled Care) are significantly underachieving against their savings targets.
(Recommendation 7)
- 23 The Health Board receives additional external scrutiny from Welsh Government over its finances following changes to its escalation status⁸. For the 'expected outcomes for its approach to savings', the Health Board needs to ensure that there are robust policies and processes around savings leading to the delivery of short-term and longer-term transformational savings. Progress against these outcomes is routinely monitored by Board and the F&PC alongside specific monitoring meetings with Welsh Government's Finance Team at the NHS Executive. As at Sept 2024, the Health Board reported that it was undertaking work to address all of its escalation objectives around Finance, Strategy and Planning.
- 24 The Health Board has clearly identified its strategic financial risks and has appropriate financial management structures in place, including the Board Assurance Framework and Corporate Risk Register. The mitigating actions and controls for these risks appear to be reasonable, and they are regularly reviewed by relevant committees and the Board. However, the Health Board's financial challenges remain, which suggests that the controls and actions might not be achieving their desired impact. **(Recommendation 8)**
- 25 The Health Board continues to carry risk within its identified savings schemes. Whilst it had identified the majority of its savings schemes for the submission of its 2023-24 Annual Plan, 37% of these savings were categorised as red meaning they carried a significantly high delivery risk. 16% of these red risk schemes remained undelivered at the end of 2023-24. The Health Board's 2024-25 Annual Plan identified 89% of the savings as either category green or amber with the remainder

⁸ In January 2024 Welsh Government escalated the Health Board to Targeted Intervention for Finance, Strategy and Planning under its Escalation Framework. This has seen an enhanced level of scrutiny by Welsh Government over the progress the Health Board is making against a defined set of 'Expected Outcomes'.

categorised as red. Whilst this is an improvement on the 2023-24 position, the underlying savings figure (see **paragraph 16**) required to achieve its control total for 2024-25 is significantly greater than the Health Boards current reported savings target. **(Recommendation 9)**

- 26 The Health Board has clearly prescribed processes in place to evaluate and improve cost savings arrangements which draws on audit findings and best practice. The Health Board's Value and Sustainability Board and its Compendium tool are also key mechanisms used to share initiatives, best practice, and learning in both identifying and delivering savings. However, the extent to which the Health Board shares learning across divisions and directorates for schemes that have failed to deliver or underperformed is not clearly defined or systematically applied across the organisation. **(Recommendation 10)**

Recommendations

- 27 **Exhibit 2** details the recommendations arising from this audit. The Health Board's management response to our recommendations is summarised in **Appendix 2**.

Exhibit 1: Recommendations

Recommendations	
R1	The Health Board needs to work quickly with its divisions and directorates to develop and implement a more consistent approach to the adoption of savings opportunities within its compendium, which will also need to include a greater level of transformative, cross service efficiencies and recurrent savings, to ensure its savings are put on a more sustainable footing. (Paragraph 12 and 15)
R2.1	The Health Board should clearly demonstrate how the savings and efficiency ideas that it canvasses from its staff are then used to inform and shape deliverable savings schemes. (Paragraph 13)
R2.2	The Health board should put clear arrangements in place to canvass savings and efficiency ideas from service users and other stakeholders (Paragraph 13)
R3	The Health Board should ensure that all relevant staff are applying its quality impact assessment approach on savings schemes in a consistent manner. (Paragraph 14)

Recommendations

- R4 The Health Board should strengthen its approach to the reporting of cost savings by ensuring that future savings reports to Board and committees articulate all the savings the organisation needs to deliver each year to meet its Welsh Government control total deficit. **(Paragraph 16)**
- R5 The Health Board should continue to refine and update its medium-term financial plan (route map) to 2026-27 based on internal and external delivery risks and quickly take corrective action where there is slippage in its planned financial trajectory. **(Paragraph 19)**
- R6 The Health Board should ensure that its current financial training and capacity building for its budget holders is sufficiently fit for purpose. **(Paragraph 20)**
- R7 The Health Board should ensure its accountabilities framework is working as intended and acting as an appropriate lever to manage divisional and directorate underperformance against savings targets. **(Paragraph 22)**
- R8 The Health Board and its committees need to ensure that its identified controls and mitigating action for its strategic financial risks and fit for purpose and that their ongoing scrutiny clearly identifies remedial action where these controls are not having the desired impact. **(Paragraph 24)**
- R9 The Health Board should continue to strengthen its approach to identifying and developing saving schemes with a view reducing the number of schemes that are rated as red, and to maintain a focus on moving its red and amber schemes to green. **(Paragraph 25)**
- R10 The Health Board should strengthen its current mechanisms for sharing learning on savings schemes to ensure that it gather and then disseminate learning from schemes that have failed or underdelivered. **(Paragraph 26)**

Appendix 1

Audit methods

Exhibit 2 below sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Board and Committees agendas, papers, and minutes. • Key organisational strategies and plans. • Savings benchmarking data. • Key risk management documents, including the Board Assurance Framework and Corporate Risk Register. • Key reports and plans relation to organisational finances and savings. • Reports prepared by the Internal Audit service.
Interviews	We interviewed the following senior officers: • Executive Director of Finance and Procurement

Element of audit approach	Description
	• Medical Director and Deputy Chief Executive • Director of Workforce and Organisational Development • Interim General Manager - Scheduled Care • Chief Operating Officer • General Manager – Medicine Division • Exec Director Strategy Planning and Partnership • Head of Strategic Financial Planning
Observations	• Finance and Planning Committee

Appendix 2

Management response to audit recommendations

Exhibit 3: Aneurin Bevan University Health Board management response to our audit recommendations.

Ref	Recommendation	Management response	Completion date	Responsible officer (title)
R1	The Health Board needs to work quickly with its divisions and directorates to develop and implement a more consistent approach to the adoption of savings opportunities within its compendium, which will also need to include a greater level of transformative, cross service efficiencies and recurrent savings, to	The Health Board will continue to populate and promote the ‘Opportunities Compendium’ with up-to-date benchmarking intelligence with information from multiple sources, including CHKS, GIRFT, Annual Costing Returns and NHS Benchmarking network, as well as other best practice exemplars and guidelines including the NHS Wales Vault and National Value & Sustainability Board recommendations.	Completed as part of existing process	Executive Director of Finance

Ref	Recommendation	Management response	Completion date	Responsible officer (title)
	ensure its savings are put on a more sustainable footing.	This resource has been developed through the Finance Directorate over many years and is shared and communicated regularly with the Executive Team, Divisional services as part of in year and annual planning considerations, the Finance & Performance Committee and the Value and Sustainability Board. Operational investments, changes and improvement plans include an assessment of benchmarks and comparators as part of evaluation. These opportunities may impact both system and specialty level savings including short term and long-term service sustainability from theatre productivity through to potential bed rationalisation and thus site reductions. The expectation is that budget holders will review, consider and identify actions to implement appropriate changes to achieve better efficiency and cost reductions, while maintaining safe care for patients. The Health Board will continue to advocate the resource as a source of improvement opportunities and expect budget holders and service managers to utilise it to identify and deliver financial benefits and efficiency delivery.		

Ref	Recommendation	Management response	Completion date	Responsible officer (title)
R2	R2.1 The Health Board should clearly demonstrate how the savings and efficiency ideas that it canvasses from its staff are then used to inform and shape deliverable savings schemes. R2.2 The Health board should put clear arrangements in place to canvass savings and efficiency ideas from service users and other stakeholders	The first tranche of savings ideas from staff have been reviewed and assessed by the Health Board Value and Sustainability theme executive leads. The plethora of ideas received identified many issues that were being progressed where appropriate to do so and new ideas shared directly with service leads for consideration. Feedback on key initiatives is given through CEO briefings and the frequency of this will be increased. A second exercise to review more recent ideas received is being progressed. In addition, regular finance & savings updates are provided to 'Staff side' at the Trades Union Partnership Forum meetings. Arrangements to identify opportunities for improvement from patients and stakeholders are based on a range of approaches, including patient involvement in consultations, specific project work (e.g. Value based healthcare projects) and receiving feedback from Llais. Opportunities to learn from patient compliments and complaints are also taken as part of learning across all services. Patient stories are also used as a mechanism to identify good practice. We are also promoting the Bevan Commission campaign of "Silly Rules" within the organisation, encouraging service users, stakeholders and staff to identify opportunities, through the review of "silly rules" to improve, streamline or	March 2025	V&SB Theme Lead Executive Directors

Ref	Recommendation	Management response	Completion date	Responsible officer (title)
		where appropriate remove steps, requirements or processes. We will review the outcome of this work to see if there are local opportunities.		
R3	The Health Board should ensure that all relevant staff are applying its quality impact assessment approach on savings schemes in a consistent manner.	The ABUHB QIA process was developed and formally signed off by the Board in September 2023, this is the process all savings proposals are required to progress through if they are likely to have a direct impact on provision of patient care. Guidance on the application and criteria for the savings and QIA process has been shared by Planning leads as part of the Annual planning process, additionally the Executive team review savings to ensure the process is appropriately followed.	Completed as part of existing process	Executive Director of Strategy, Planning & Partnerships
R4	The Health Board should strengthen its approach to the reporting of cost savings by ensuring that future savings reports to Board and committees articulate all the savings the organisation needs to deliver each year to meet its	The Board has well established best practice mechanisms for transparently reporting the forecast financial and savings position which have been subject to Welsh Government and audit review. Health Board savings reporting is aligned to the guidelines and requirements of the Welsh Government financial management regime.	Health Board reporting will continue in current format which is compliant with Welsh Government guidelines	Executive Director of Finance

Ref	Recommendation	Management response	Completion date	Responsible officer (title)
	Welsh Government control total deficit.	The overall health board expenditure forecast above funded levels, compared with the level of savings planned identifies a shortfall as the Health Board forecast deficit. This is reported against the statutory duty to break even as well as clearly stating the comparison with the control total set by Welsh Government.	and best practice.	
R5	The Health Board should continue to refine and update its medium-term financial plan (route map) to 2026-27 based on internal and external delivery risks and quickly take corrective action where there is slippage in its planned financial trajectory.	The Health Board's 'Route map to recovery' was approved by the Board in July 2024, as part of the Value and Sustainability Board savings identification process and the annual planning process the detailed actions will be further developed. The 2025/26 Planning process will confirm the delivery plan against the route map.	March 2025	Chief Executive Officer & Executive Director of Finance
R6	The Health Board should ensure that its current financial training and capacity building for its budget holders is sufficiently fit for purpose.	The Health Board has several staff education, training, guidelines and development offers to improve financial and business acumen, these are considered as fit for purpose and are regularly revised and added to. Many of these were developed as a result of the Board becoming aware of the	Complete as part of existing process.	Executive Director of Finance/ Executive Director of

Ref	Recommendation	Management response	Completion date	Responsible officer (title)
		need for improvements in some staff budget and business management capabilities. The current portfolio includes: • Induction training including Financial Control Procedures • Specific new budget holder finance system training • Specific new budget holder procurement training • Specific electronic staff record training • Budget management e-learning tool • Roster management training • Medical Job planning training • Procurement update training sessions • Contract management FCP awareness training • Counter Fraud training • Clinical Director business training programme (CDx) • Directorate Manager business training programme (DMx) • Business Case content/process guidance • Governance and control self-assessment tools • Value Based Healthcare training programme		Workforce and Organisational Development/ Executive Director of Nursing

Ref	Recommendation	Management response	Completion date	Responsible officer (title)
		Quality Improvement training programme Plus, bespoke or repeat training on request or relevant to business need provided by expert business partners. Additionally, the Board will be examining recruitment processes to ensure financial competencies are adequately tested. We are also working with HEIW to contribute to the development of a framework for management competencies, of which, financial and business acumen along with budget management will need to feature strongly.		
R7	The Health Board should ensure its performance and accountability framework is working as intended and acting as an appropriate lever to manage divisional and directorate underperformance against savings targets.	The Board has established a performance and accountability framework that operates an assessment of performance that may invoke management escalation arrangements where performance is not as expected. This framework was approved by the Board in September 2023. This specifically includes financial performance measured by budget holder budget variance.	May 2025	Executive Director of Strategy, Planning & Partnerships

Ref	Recommendation	Management response	Completion date	Responsible officer (title)
		Where adverse performance is identified, and triggers are met the budget holder may be subject to escalation measures. This is discussed by the executive team. Savings delivery performance is an element of this process however this is given greater focus as part of divisional assurance reporting and Value and Sustainability Board reporting. The Performance and Accountability arrangements are to be reviewed as part of the 12-month review of the Performance Management Framework.		
R8	The Health Board and its committees need to ensure that its identified controls and mitigating action for its strategic financial risks and fit for purpose and that their ongoing scrutiny clearly identifies remedial action where these controls are not having the desired impact.	As a simple measure of the system effectiveness and delivery of the desired impact the observation is noted, as the Board is reporting a deficit. The Board would appreciate clarity on the assessment of whether the controls established are an issue or whether the remedial actions are an issue to enable the appropriate remedial action to be developed. The Board does accept that further savings are achievable and will need to be delivered, however the Board cannot make savings without reference to the context in which it operates, for example responding to system pressures and achieving government elective care targets, some of which	Completed - Existing governance mechanisms will continue.	Executive Director of Finance

Ref	Recommendation	Management response	Completion date	Responsible officer (title)
		are externally driven beyond the control of the health board e.g. emergency demand and availability of social care. The safety of patients is the prime objective of the health board. See response to R7 above which refers to a review of our performance accountability framework which forms part of improving delivery.		
R9	The Health Board should continue to strengthen its approach to identifying and developing saving schemes with a view reducing the number of schemes that are rated as red, and to maintain a focus on moving its red and amber schemes to green.	The Health Board has delivered some of the highest value savings across Wales for 2023/24 and expected for 2024/25. The Board will continue to identify opportunities to progress as savings and efficiencies under its current Value & Sustainability Board mechanisms, with further escalation of delivery through delegated budget leads and through the accountability framework arrangements. The route map to recovery will act as a steer for strategic themes along with key programme workstreams. External factors referenced in response to R7 will influence the pace of delivery.	Completed	V&SB theme lead Executive Directors

Ref	Recommendation	Management response	Completion date	Responsible officer (title)
R10	The Health Board should strengthen its current mechanisms for sharing learning on savings schemes to ensure that it gather and then disseminate learning from schemes that have failed or underdelivered.	The Board has an established mechanism for reporting all saving schemes status, these reports are shared with all budget holders as part of the Value & Sustainability Board process and successful and failing schemes are discussed to promote shared learning. Where high value schemes are failing these are explicitly considered and reviewed further to determine what mitigating action may be possible.	Completed as part of existing process	V&SB theme lead Executive Directors



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Summary report

About this report

- 1 This report sets out the findings from the Auditor General's 2024 structured assessment work at Aneurin Bevan University Health Board. Our structured assessment work is designed to help discharge the Auditor General's statutory requirement under section 61 of the Public Audit (Wales) Act 2004 to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources. Our review of the Health Board's corporate approach to setting new well-being objectives in accordance with the sustainable development principle was undertaken to help discharge the Auditor General's duties under section 15 of the Well-being of Future Generations (Wales) Act 2015.
- 2 Our 2024 Structured Assessment work took place at a time when NHS bodies were continuing to respond to a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. In addition, NHS bodies are still dealing with the legacy of the COVID-19 pandemic. More than ever, therefore, NHS bodies and their Boards need to have sound corporate governance arrangements that can provide assurance to themselves, the public, and key stakeholders that the necessary action is being taken to deliver high-quality, safe and responsive services, and that public money is being spent wisely.
- 3 The key focus of the work has been on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on:
 - corporate approach to planning;
 - corporate approach to financial management;
 - board transparency, cohesion, and effectiveness; and
 - corporate systems of assurance.We have not reviewed the Health Board's operational arrangements as part of this work.
- 4 Our work has been informed by our previous structured assessment work, which has been developed and refined over a number of years. It has also been informed by:
 - model Standing Orders, Reservation and Delegation of Powers
 - model Standing Financial Instructions
 - relevant Welsh Government health circulars and guidance
 - the Good Governance Guide for NHS Wales Boards (Second Edition)
 - other relevant good practice guidesWe undertook our work between June 2024 and September 2024. The methods we used to deliver our work are summarised in **Appendix 1**. Our work was

conducted in accordance with the auditing standards set by the International Organization of Supreme Audit Institutions.

- 5 We also provide an update in this report on the Health Board's progress in addressing outstanding recommendations identified in previous structured assessment reports in **Appendix 2**.

Key findings

- 6 Overall, we found that **the Health Board's Board and committee governance arrangements are stable and generally effective. However, given its financial and performance challenges, the Health Board's development of a new long-term strategy and delivery of its three-year route map are crucial to enabling the organisation to transform services to meet current and future demand.**
- we considered whether the Health Board has a sound corporate approach to producing strategies and corporate plans and overseeing their delivery. We found that the Health Board's approach for developing and delivering strategic plans is not yet enabling it to deliver sustainable services that meet demand. It is imperative that its ongoing long-term strategy development provides the basis and ambition for planning and transforming services that meet current and future needs.
 - we considered whether the Health Board has a sound corporate approach to managing its financial resources. We found that the Health Board is improving its financial controls and has a stronger focus on value and savings delivery. However, its significant ongoing financial challenges suggest that it needs a longer-term and more detailed financial strategy aligned to sustainable care models.
 - we considered whether the Health Board's Board conducts its business appropriately, effectively, and transparently. We found that despite reasonably effective Board and committee arrangements, the Health Board should increase the frequency of the finance and performance committees' meetings to enable more detailed scrutiny and oversight, increase the number of patient safety leadership walkrounds and improve committee chairs' reporting to Board.
 - we considered whether the Health Board has a sound corporate approach to managing risks, performance, and the quality and safety of services. We found that while the Health Board is strengthening its assurance arrangements and its performance management approach is improving, further work is needed.

Recommendations

7 **Exhibit 1** details the recommendations arising from our work. The Health Board's response to our recommendations is summarised in **Appendix 3**.

Exhibit 1: 2024 recommendations

Recommendations	
R1	As part of its ongoing long-term strategy and clinical services plan development, the Health Board should: R1.1 Ensure the organisation's new long-term strategy and clinical services plan clearly defines the required sustainable service solutions and decisions for the medium to longer term. This should include a strong focus on population health and prevention. (Paragraph 14) R1.2 Ensure there is comprehensive engagement with clinical and other staff across all domains of the organisations service provision to feed into the development of the clinical services plan. (Paragraph 15) R1.3 Publish well-being objectives either alongside or within its new long-term strategy and ensure Well-being of Future Generations (2015) Act requirements are an integral part of the strategy. (Paragraph 16)
R2	To enable more effective scrutiny of delivery of corporate plans and strategies, the Health Board should ensure that progress reports are clear and contain performance targets and comparative benchmarks, where possible. Reports should also contain clear progress against established milestones to aid scrutiny of progress. (Paragraph 28)
R3	To become financially sustainable in the longer-term, the Health Board should develop a detailed longer-term financial plan that is linked to the new long term strategy currently in development and three-year route-map and ensure progress against delivery is monitored appropriately. (Paragraph 39)
R4	The Health Board should strengthen its oversight of Standing Financial Instruction and Single Tender Actions by:

Recommendations

- R4.1 introducing a self-assessment on Standing Financial Instruction compliance; **(Paragraph 43)** and
- R4.2 ensuring Single Tender Action reports include total contract values, setting out whether Board or Welsh Government approval was needed, and provide trend analysis of numbers and total values of Single Tender Actions for comparative periods in previous years. **(Paragraph 43)**

- R5 To enable deeper scrutiny of operational finance and performance the Health Board should increase the frequency of the finance and performance committee meetings. **(Paragraph 48)**

- R6 The Health Board should ensure there is effective separation of responsibilities between the role of the Health Board Chair and the Chair of the Partnerships, Population Health and Planning Committee. The Health Board should seek to appoint a separate committee chair from the wider cohort of independent members. **(Paragraph 64).**

- R7 The Health Board needs to allow sufficient time on Board meeting agendas for the committee chairs to report assurance to the Board and escalate any concerns. **(Paragraph 67)**

- R8 The Health Board should ensure there is a clear approach that links the strategic risks in its risk register to the strategic objectives in its annual plan. **(Paragraph 86)**

- R9 The Health Board should ensure there is a stronger focus on primary and community care performance within its Integrated Performance reports. **(Paragraph 95)**

Detailed report

Corporate approach to planning

- 8 We considered whether the Health Board has a sound corporate approach to producing strategies and corporate plans and overseeing their delivery.
- 9 We found that the **Health Board's approach to developing and delivering strategic plans is reasonably effective. However, the approach is not yet enabling it to deliver sustainable services that meet demand. As a result, it is imperative that its ongoing long-term strategy development provides the basis and ambition for planning and transforming services that meet current and future needs.**

Corporate approach to producing strategies and plans

- 10 We considered whether the Health Board has a sound corporate approach to producing, overseeing, and scrutinising the development of strategies and corporate plans. We were specifically looking for evidence of:
- a clear Board approved vision, appropriate objectives and a long-term strategy in place which are future-focussed, rooted in population health, and informed by a detailed and comprehensive analysis of needs, opportunities, challenges, and risks;
 - the long-term strategy underpinned by an appropriate Board approved long-term clinical strategy;
 - appropriate and effective corporate arrangements in place for developing and producing the Integrated Medium-Term Plan (IMTP), and other corporate plans; and
 - the Board appropriately scrutinising the IMTP and other corporate plans prior to their approval.
- 11 We found that **the Health Board has generally effective arrangements for developing strategic plans built on good engagement. Developing a new long-term strategy is a clear priority for the Health Board. However, it needs to ensure clinical services plans are developed in consultation with all relevant stakeholders and fully reflects the changes needed to further deliver sustainable clinical service models.**
- 12 The Health Board's Clinical Futures Strategy, its long-term organisational strategy, has been extant for more than a decade. However, the Health Board is now working in a more challenging environment and dealing with the legacy of the COVID-19 pandemic, increasing demand, and greater financial pressures. It is also seeing increasing oversight by Welsh Government following the recent change to its escalation status¹. Although the Health Board's extant Clinical Futures Strategy

¹ Targeted Intervention (Level 4) for finance, strategy and planning, and Enhanced Monitoring (Level 3) for urgent and emergency care at the Grange University Hospital.

has helped guide service sustainable developments and supporting infrastructure, it needs to be updated to enable the organisation to sustainably meet population health needs and address the current challenges it faces. A symptom of this is reflected in the performance and financial challenges the Health Board is currently facing.

- 13 As a result, the Health Board is currently developing a new long-term strategy that will focus on population health, community-based services, and providing sustainable acute services. There is a clear timeline and governance arrangements in place for the strategy development, which the Board agreed in September 2023. The Health Board is also focussing on its replacement clinical futures strategy and at the time of our work implementing its enhanced Local General hospital (ELGH) reconfiguration programme.
- 14 The Health Board aimed to publish the long-term strategy in September 2024 but has since revised this to January 2025. Despite this, the Health Board's timetable remains ambitious especially considering the need for it to fully consider the changes needed to create sustainable clinical service models. Immediate pressures relate to service performance and finance, which require improvements in the acute setting and stronger cost control. However, longer-term population health challenges and the expected aging patient demographic are likely to require a far greater focus on health and prevention, targeting inequalities, as well as an increased focus on integrated community services. The Health Board, therefore, will need to ensure its long-term strategy clearly defines the required changes and sustainable service solutions that are needed in both the medium- and longer-term whilst maintaining adequate focus on addressing immediate performance and financial challenges. **(Recommendation 1.1)**
- 15 The Health Board is actively engaging with the community to inform its new strategy. Its approach - 'A Conversation for a Healthy Future' - focusses on the single question of "What's important to feel healthy?" Whilst its community focussed strategy engagement is positive, the Health Board also needs to ensure sufficient and full engagement with clinical and administrative staff across the organisation as part of its clinical strategy development. **(Recommendation 1.2)**
- 16 The Health Board also needs to take the opportunity presented through the development of its new long-term strategy to more fully integrate the requirements of the Well-being of Future Generations (Wales) Act 2015 across the organisation and set well-being objectives **(Recommendation 1.3)**. We discuss this in more detail in the following section.
- 17 The Health Board is working to an Annual Plan for 2024-25 as it was unable to submit to Welsh Government an approvable, financially balanced Integrated Medium-Term Plan for 2024-27. Its 2024-25 Annual Plan continues to build on the

Health Board's 'life course approach'², setting out outcomes and measures to achieve them. While the actions in the plan are reasonably clear for the current 12-month period, there is less clarity on its proposed actions beyond this. We also understand that the Health Board received some challenge from Welsh Government on the draft plan this year requiring it, for example, to demonstrate greater ambition for improvement and service recovery.

- 18 The Health Board continues to demonstrate a good approach to engaging with both internal and external stakeholders in the development of the Annual Plan. It routinely shares draft strategies/plans with Independent Members supported by discussion, where needed, at Board Development sessions before formal approval at public Board meetings.

Corporate approach to setting well-being objectives

- 19 We considered whether the Health Board has a sound corporate approach to setting its well-being objectives in accordance with the sustainable development principle³. We were specifically looking for evidence of:
- appropriate arrangements in place for setting well-being objectives which are underpinned by the sustainable development principle;
 - appropriate consideration given to how the organisation will ensure delivery of its well-being objectives; and
 - appropriate arrangements in place to monitor progress and improve how the organisation applies the sustainable development principle.
- 20 We found that **while the Health Board works well with partners to assess and understand population needs, it needs to review its well-being objectives and ensure their delivery features more explicitly in corporate plans.**
- 21 During 2023-24, the Health Board worked with its partners on the Gwent Public Service Board to use the Gwent Well-being Assessment to inform the development of a regional well-being plan. This plan, which covers the period 2023-28, includes broad strategic aims and steps to improve population well-being in the region, including improving the availability and quality of housing, tackling the impact of the cost of living, addressing climate change, and improving health and well-being.
- 22 The Health Board has also worked collaboratively with partners to develop the 2023 Gwent Joint Strategic Assessment. This provides an evidence base to inform Health Board planning and priority setting. The Gwent partners have also adopted

² The Health Board has defined five life course goals which focus on what matters to individuals and what will improve their healthy life expectancy, from giving every child the best start in life, to dying well as part of life.

³ Under The Well-being of Future Generations (Wales) Act 2015, the Health Board is required to set and publish well-being objectives that are designed to maximise its contribution to achieving each of the well-being goals.

the 'Marmot' principles⁴, which align well to many of the Well-being of Future Generation (Wales) Act 2015 requirements.

- 23 While the Health Board is working in partnership focussing on population well-being and its 'life-course' approach, it is also required to be clear as an organisation on its well-being objectives and review and publish these periodically. The Health Board last formally published its well-being objectives and well-being statement in 2017-18. As mentioned previously, it now needs to take the opportunity presented by the long-term strategy development to review these (see **Recommendation 1.3**).

Corporate approach to overseeing the delivery of strategies and plans

- 24 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising the implementation and delivery of corporate plans. We were specifically looking for evidence of:
- corporate plans, including the IMTP, containing clear strategic priorities/objectives and SMART⁵ milestones, targets, and outcomes that aid monitoring and reporting; and
 - the Board appropriately monitoring the implementation and delivery of corporate plans, including the IMTP.
- 25 We found that **corporate plans are in the main supported by SMART actions; however, some progress reports can be overly narrative and lack clarity on progress and outcomes.**
- 26 The Health Board's corporate plans and strategies include clear objectives and measurable outcomes. This is the case both for its current Annual Plan and Quality Strategy, which we reviewed. Both contain appropriate information about priorities, supporting actions, milestones for delivery and intended outcomes.
- 27 Our 2023 Structured Assessment recommended the Health Board strengthen its IMTP/Annual Plan progress report. The Health Board has improved its approach to reporting by using its quarterly progress report to track progress in delivering its plan priorities and milestones, as well as ministerial priorities. There is a clear summary of progress with an assessment of whether actions are off track and what steps are being taken to address any performance concerns (see **Appendix 2 Structured Assessment 2023 R7**).
- 28 However, the Health Board needs to ensure that reporting on the progress of other strategies and plans is fit for purpose. For example, the Quality Strategy quarterly

⁴ The 'Marmot' principles recognises that health and health inequalities are mostly shaped by social determinants, i.e. the environment in which people live and their lifestyles.

⁵ Specific, measurable, achievable, relevant, and time-bound

report which was last presented in September 2024 was long and the presentation was difficult to read. This report also lacked detail on performance targets and comparative benchmarks which would aid readers in identifying areas of concern. We have seen similar issues in the July 2024 People Strategy update. While setting out progress made over the past 12 months, it was again very narrative based which made it difficult to establish progress and outcomes against the set milestones. **(Recommendation 2)**

Corporate approach to managing financial resources

- 29 We considered whether the Health Board has a sound corporate approach to managing its financial resources.
- 30 We found that the **Health Board is improving its financial controls and has a stronger focus on value and savings delivery. However, its significant ongoing financial challenges suggest that it needs a longer-term and detailed financial strategy aligned to sustainable care models.**

Financial objectives

- 31 We considered whether the Health Board has a sound corporate approach to meeting its key financial objectives. We were specifically looking for evidence of:
- the organisation meeting its financial objectives and duties for 2023-24, and the rolling three-year period of 2021-22 to 2023-24; and
 - the organisation being on course to meet its objectives and duties in 2024-25.
- 32 We found that **despite additional funding from Welsh Government, the Health Board did not meet its key financial objectives and duties for 2023-24. Furthermore, it will be challenging to achieve its key financial targets for 2022-25.**
- 33 The Health Board did not meet its financial objectives and duties for 2023-24. The original Financial Plan for 2023-24 forecasted an in-year deficit of £112.8 million. However, it received £88.3 million of extra funding from Welsh Government in November 2023⁶. As a result, it closed the 2023-24 year with a deficit of £49.7 million, thus failing to meet its deficit control total of £13 million and breaching its duty to break even over the three-year rolling period 2021-22 to 2023-24. The Health Board did, however, have a small underspend on its capital resource limit.
- 34 The Health Board's current and forecast financial position for 2024-25 is challenging. Concerns about the financial position contributed to the Welsh

⁶ Written Statement: LHB Allocations and Target Control Totals

Government's decision to escalate the Health Board to targeted intervention⁷ in February 2024. As a result of the 2023-24 year-end position and ongoing underlying deficit, the Health Board was unable to submit a balanced Financial Plan for 2024-2027. Instead, it is working to an Annual Plan deficit of £48.9 million for 2024-25, which the Board set at the beginning of the financial year. The Health Board was showing a slight improvement in its forecasted year end position at Month 5 2023-24 (£47.8 million deficit). However, this has improved further. In December 2024, the Welsh Government made an in-year recurrent £9.5 million allocation and a conditionally recurrent £31 million allocation to the Health Board. The conditions for gaining the £31 million allocation recurrently include meeting the revised control total, ensuring a financially balanced IMTP and securing improvements in planned care and regional working. Based on the additional allocation, the revised year end position is expected to be a forecast deficit of £7.3 million, which is also the Health Board's new revised Target Control Total for the 2024-25 financial year.

Corporate approach to financial planning

- 35 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising financial planning. We were specifically looking for evidence of:
- clear and robust corporate financial planning arrangements in place;
 - the Board appropriately scrutinising financial plans prior to their approval;
 - sustainable, realistic, and accurately costed savings and cost improvement plans in place which are designed to support financial sustainability and service transformation; and
 - the Board appropriately scrutinising savings and cost improvement plans prior to their approval.
- 36 We found that **while there is improving engagement and oversight of financial planning, there is a clear need to develop a more detailed longer-term financial recovery plan linked to the emerging long-term strategy and three-year financial route-map.**
- 37 The Health Board has improving arrangements for Board and committee oversight of financial planning. Board members recognise the financial challenges facing the organisation, which include the operational pressures and external factors driving significant growth in costs. This year's Financial Plan was developed with good engagement from Board members through a series of Board briefings and Board Development Sessions.
- 38 The Health Board delivered a significant savings programme in 2023-24, achieving savings of £43 million, the highest level for the Health Board since its inception,

⁷ <https://www.gov.wales/nhs-wales-escalation-and-intervention-arrangements>

and the highest in Wales. Savings plans for 2024-25 remain ambitious but will be challenging to deliver in full. The Health Board has strengthened its structures and resources to support divisional savings delivery and there is stronger accountability and shared ownership for savings led by the bi-weekly Value and Sustainability Board. An Executive Director leads each theme supported by a programme board for most areas. As at Month 4 2024-25, the Health Board was planning to achieve £42.2 million in savings against a target of £40.5 million. Whilst it was making good progress in 'de-risking' the saving schemes (i.e. ensuring actions are taken to make savings realistically deliverable), it had only delivered £9.9 million of actual savings, leaving a challenging delivery target for the remainder of the year.

- 39 Despite the progress with savings arrangements, a savings focussed approach is unlikely to lead to longer-term financial sustainability. Indeed, our 2024 Review of Cost Savings Arrangements found that the Health Board needs to develop a longer-term financial plan focused on achieving recurrent savings from transformational service change. The Health Board, therefore, needs to develop a detailed longer-term financial plan linked to its long-term strategy and sustainable service models. The Health Board has started this process and is moving in the right direction with the three- year route-map to financial sustainability, which was approved by Board in July 2024. This sets out strategic service priorities and the financial aims and assumptions of the Health Board. The three-year route-map links to changes and efficiencies required through service and estate reconfiguration, workforce redesign and productive working. It places increasing and substantial reliance on truly recurring cashable efficiencies, but there needs to be greater clarity to indicate how the Health Board will achieve this **(Recommendation 3)**. There also needs to be consideration of health cost inflation associated with continued growing and changing service demand.

Corporate approach to financial management

- 40 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising financial management. We were specifically looking for evidence of:
- effective controls in place that ensure compliance with Standing Financial Instructions and Schemes of Reservation and Delegation;
 - the Board maintaining appropriate oversight of arrangements and performance relating to single tender actions, special payments, losses, and counter-fraud;
 - effective financial management arrangements in place which enable the Board to understand cost drivers and how they impact on the delivery of strategic objectives; and
 - the organisation's financial statements for 2023-24 were submitted on time, contained no material misstatements, and received a clean audit opinion.

- 41 We found that **the Health Board has a generally good approach to overseeing and scrutinising financial management.**
- 42 The Board reviews Standing Orders and Standing Financial Instructions frequently, the last time being September 2024. Following a review of delegated limits across Wales, the Board approved a revision to the Scheme of Delegation in September 2024 which raised the general financial limits. It remains responsible for the approval of business cases valued over £1 million. However, the Health Board is yet to ensure clear delegated responsibility for the achievement of financial savings below executive levels in the Scheme of Delegation (see **Appendix 2 Structured Assessment 2022 R7**).
- 43 The Board delegates financial oversight to the Audit, Risk and Assurance Committee and the Finance and Performance Committee, which discharge their responsibilities appropriately. The Audit, Risk and Assurance Committee gain assurance from wider regular internal and external assurance reports in relation for financial controls and stewardship. These include overseeing reports on financial compliance, and the programme of internal audit and counter fraud work. However, there are some areas that could be improved in relation to monitoring Standing Financial Instruction compliance and single tender actions. (**Recommendations 4.1 and 4.2**)
- 44 The Health Board submitted its draft Financial Statements for external audit within the required timescales, following consideration by the Audit, Risk and Assurance Committee in July 2024. For 2023-24, we issued an unqualified true and fair audit opinion but issued a qualified regularity opinion because the Health Board did not meet its revenue resource allocation over the rolling three-year period 2021-22 to 2023-24.

Board oversight of financial performance

- 45 We considered whether the Board appropriately oversees and scrutinises financial performance. We were specifically looking for evidence of:
- the Board receiving accurate, transparent, and timely reports on financial performance, as well as the key financial challenges, risks, and mitigating actions; and
 - the Board appropriately scrutinising the ongoing assessments of the organisation's financial position.
- 46 We found that **the Health Board and committees appropriately oversee and scrutinise financial performance, but needs to increase the frequency of the Finance and Performance Committee meetings to enable more detailed scrutiny and oversight**
- 47 The Board and Finance and Performance Committee continue to oversee the Health Board's financial performance, with finance reports providing sufficient information to enable appropriate scrutiny and oversight. Reports are transparent and supported by detailed explanation from the relevant Executive leads. They

also clearly highlight key financial challenges, risks, and mitigating actions and the potential impact on service quality and safety. The Board appropriately scrutinises the ongoing assessments of the organisation's financial position.

- 48 As noted previously, the Health Board continues to experience substantial financial challenges. Although the Finance and Performance Committee is well established, it only meets quarterly. As a result, it is unable to provide more detailed oversight of operational financial performance. Increasing the frequency of this committee to bi-monthly would enable the committee to undertake deeper dives into divisional financial and performance matters. **(Recommendation 5)**
- 49 While reports give a good overview of the financial position in the short-term, the current reporting approach makes it difficult to see how the Health Board will recover its position in the medium- to longer-term. Reports, therefore, should also focus on the Health Board's progress in delivering financially sustainable service models linked to service productivity, value, and efficiency (see **Recommendation 3**).

Board transparency, effectiveness, and cohesion

- 50 We considered whether the Health Board's Board conducts its business appropriately, effectively, and transparently.
- 51 We found **despite reasonably effective Board and committee arrangements, the Health Board should, increase the number of patient safety leadership walkrounds, and improve committee chairs' reporting to Board.**

Public transparency of Board business

- 52 We considered whether the Board promotes and demonstrates a commitment to public transparency of board and committee business. We were specifically looking for evidence of Board and committee meetings:
- that are accessible to the public;
 - papers being made publicly available in advance of meetings; and
 - business and decision-making being conducted transparently.
- 53 We found that **the Board and committees continue to operate transparently with open discussion on key Health Board challenges.**
- 54 The Board continues to demonstrate a commitment to public transparency of board and committee business. Members of the public can continue to observe public Board meetings through the live stream, or by attending in person. The Health Board provides signposting and instructions to join upcoming Board meetings via the homepage on its website and its social media channels. However, public take up is low. Recordings of the public Board meetings are made publicly available 24 hours after the meeting. Private sessions of the Board are reserved for sensitive

and confidential matters. Where private sessions are used, a summary of discussions is provided at the subsequent public Board meeting.

- 55 Board members hold open and frank discussions in Board and committee meetings on the Health Board's performance, finance, and quality challenges. Executive Directors are open about the Health Board's challenges and the priority areas for action and feel well supported by the entire Board in responding to them.
- 56 The Health Board does not livestream or publish recordings of its committee meetings, although we understand that there are plans to start this in January 2025 (see **Appendix 2 Structured Assessment 2023 R1**). Unconfirmed committee meeting minutes are published on the Health Board's website only when included in papers for the next meeting, around 2 to 3 months after. This continues to limit timely access to records of committee business, but if live streaming of committee meetings is introduced it would improve transparency.

Arrangements to support the conduct of Board business

- 57 We considered whether there are proper and transparent arrangements in place to support the effective conduct of Board and committee business. We were specifically looking for evidence of:
- a formal, up-to-date, and publicly available Reservation and Delegation of Powers and Scheme of Delegation in place, which clearly sets out accountabilities;
 - formal, up-to-date, and publicly available Standing Orders (SOs) and Standing Financial Instructions (SFIs) in place, along with evidence of compliance; and
 - formal, up-to-date, and publicly available policies and procedures in place to promote and ensure probity and propriety.
- 58 We found that the **Health Board continues to have good arrangements to support the effective conduct of Board business and is taking action to address outdated policies.**
- 59 The Health Board continues to have adequate arrangements to support the effective conduct of Board and committee business. It has adopted the Welsh Government's Model Standing Orders and Standing Financial Instructions and the model Scheme of Delegation. As noted previously, the Health Board has reviewed the financial limits in the Scheme of Delegation, which the Board approved in September 2024. The process for declaring interests at Board and committee meetings continues and is well established.
- 60 The Health Board has increased capacity within the Corporate Governance Team this year, which has enabled improvements. This includes developing the new Risk Management Framework and updating other important policies which have been out of date. The Health Board continues to work through an improvement plan to address out of date policies. It estimates that around 55% of its policies are out of date; however, not all policies are required, and there is targeted work ongoing to

determine the status and need for these policies. Positively, in September 2024, the Board approved a new Standards of Business Conduct Policy, which includes declarations of interest, and receipts of gifts and hospitality, as the previous version was due for review. The new policy now applies to a broader range of staff, including staff at Band 8a and above.

Effectiveness of Board and committee meetings

- 61 We considered whether Board and committee meetings are conducted appropriately and effectively. We were specifically looking for evidence of:
- an appropriate, integrated, and well-functioning committee structure in place, which is aligned to key strategic priorities and risks, reflects relevant guidance, and helps discharge statutory requirements;
 - Board and committee agendas and work programmes covering all aspects of their respective Terms of Reference as well being shaped on an ongoing basis by the Board Assurance Framework;
 - well-chaired Board and committee meetings that follow agreed processes, with members observing meeting etiquette and providing a good balance of scrutiny, support, and challenge; and
 - committees receiving and acting on required assurances and providing timely and appropriate assurances to the Board.
- 62 We found that **the Board and committee structure is generally operating well. Meetings are well chaired; however, there are opportunities to strengthen the quality of information presented.**
- 63 The Board and its committees continue to have up to-date terms of reference, and annual cycles of business are regularly reviewed and updated as appropriate. Board and committee chairs are actively involved in the meeting agenda setting process. Meetings continue to be well chaired, mostly run to time, and demonstrate good discussion on key issues. Independent Members participate fully in meetings, providing reasonably effective scrutiny on the information presented. There is a continued focus on finance and digital matters in the relevant meetings, which is positive.
- 64 There have been no changes to the committee structure this year, and it provides an appropriate focus on strategy, delivery, performance, and culture. However, the Chair of the Health Board is also Chair of the Partnership's Population Health and Planning Committee. We recommend that this is reviewed to enable the committee to provide her with the assurance required as Chair of the Board **(Recommendation 6)**. The Health Board may need to revisit its committee structure once it approves the new long-term strategy to ensure it remains fit for purpose and supports the delivery of any new strategic objectives.
- 65 The recently established Clinical Advisory Forum held its inaugural meeting in July 2024. It reports to the Executive Committee, and there are clear terms of reference in place and appropriate multi-disciplinary attendance. The forum provides a

mechanism to seek essential contributions from clinicians to the Health Board's clinical, patient experience, and quality strategies. It oversees the Health Board's Quality Impact Assessment process and also functions as a clinical 'sounding board' and clinical voice, which will be important as the Health Board develops its longer-term strategy.

- 66 The Board and some committee meetings support both in-person and virtual attendance which continues to offer flexibility to Board members. The use of technology and virtual meeting etiquette is well embedded.
- 67 The Health Board has reasonably effective arrangements in place to support flows of assurance from committees to the Board and the referral of information between committees. However, the Health Board needs ensure that it allows sufficient time for the committee chairs to report assurance to the Board, and escalate issues raised during committee meetings. This should include setting out the proposed action that the committee would like the Board to take. **(Recommendation R7)**
- 68 There are appropriate processes to ensure actions identified in meetings are transferred to other committees where appropriate. The Chair of the Board continues to hold monthly meetings with Independent Members, both collectively and separately, which supports effective information sharing.
- 69 Board and committee papers are generally clear and contain the information required for effective decision making. However, many papers continue to be overly long, detailed and some do not identify clear actions when reports identify issues and underperformance. There is also opportunity to strengthen the use of benchmarking where this is appropriate. The Health Board is in the process of procuring external training to support report writing to improve the quality (see **Appendix 2 Structured Assessment 2022 R2, and 2023 R2 and R3**).

Board commitment to hearing from patients/service users and staff

- 70 We considered whether the Board promotes and demonstrates a commitment to hearing from patients/service users and staff. We were specifically looking for evidence of:
- the Board using a range of suitable approaches to hear from a diversity of patients/service users, the public and staff.
- 71 We found that **the Board has continues to demonstrate a positive commitment to hearing from staff and patients but needs to improve delivery of its programme of Patient Safety Leadership Walkrounds.**
- 72 The Health Board has an established Communications and Engagement Strategy and has continued to strengthen its arrangements to hear from patients, service

users, and staff. The introduction of the CIVICA⁸ patient feedback system has been positive, and there are examples where this information is being reviewed at the Patient Safety, Quality and Outcomes Committee. As the Health Board sets out to develop its new long-term strategy, several engagement events were being held both in the community and online.

- 73 The Health Board has continued to include a patient and public engagement item at every public Board meeting which includes a report from the citizens' voice body, 'Llais.', and patient experience presentations with patients and families attending in person. The Patient Safety, Quality, and Outcomes Committee also receives patient, and staff stories and demonstrates a commitment to listening and learning from staff, as illustrated within its performance report.
- 74 In May 2023, the Health Board restarted its Patient Safety Leadership Walkrounds. These are for Independent Members and Executive Directors and cover inpatient, outpatient, Mental Health, and community patient care areas, as well as support services throughout the Health Board. Despite good arrangements to plan the schedule of walkrounds, only 33% of the pre-arranged visits have taken place⁹. The Health Board has investigated the reasons for this and is aiming to address this issue over the next 12 months.

Board cohesiveness and commitment to continuous improvement

- 75 We considered whether the Board is stable and cohesive and demonstrates a commitment to continuous improvement. We were specifically looking for evidence of:
- a stable and cohesive Board with a cadre of senior leaders who have the appropriate capacity, skills, and experience;
 - the Board and its committees regularly reviewing their effectiveness and using the findings to inform and support continuous improvement; and
 - a relevant programme of Board development, support, and training in place.
- 76 We found that the **Board is cohesive and committed to continuous improvement, with good Board member induction and training opportunities.**
- 77 The Board is cohesive, with positive working relationships, good lines of communication, and awareness of respective roles and responsibilities amongst its members. Executive Director portfolios are appropriately balanced and have clearly defined responsibilities.
- 78 The Board has a stable cadre of Independent Member. However, the Health Board was unable to appoint a replacement Independent Member (Trade Union), and a

⁸ CIVICA is a national platform to enable NHS bodies in Wales to capture real-time feedback from users of its services.

⁹ Between May 2023 and October 2024.

decision was made to extend the current appointment for 12 months until a suitable candidate could be appointed. Positively, the Health Board has developed an internal Aspiring Board Member Programme to address this issue in the future. At the time of our work, there were three candidates on the programme. However, turnover is expected in 2025 including the Chair and Vice Chair of the Health Board, which the Health Board will need to manage carefully to maintain stability and minimise disruption.

- 79 The Health Board continues to have effective local induction arrangements for Executive Directors and Independent Members. These include meetings with other Board members and stakeholders alongside detailed training materials. Independent Members indicated they felt supported by the Board and have opportunities for learning and development.
- 80 Arrangements to support Board self-assessment continue to be effective. During 2023-24, the committees undertook a mid-year self-assessment, with the findings used to inform the annual assessment of the Board effectiveness in 2023-24. The Health Board continues to have a programme of Board development and Board briefing sessions which cover a range of topics, including urgent and emergency care, risk management, and the Health Boards Quality Strategy. Board Members continue to comment positively on the quality of these sessions.

Corporate systems of assurance

- 81 We considered whether the Health Board has a sound corporate approach to managing risks, performance, audit recommendations. We will comment separately on the Health Board's approach to managing the quality and safety of services as part of our Follow-up Review of Quality Governance Arrangements in 2025.
- 82 We found that **while the Health Board is strengthening its assurance arrangements and its performance management approach is improving, further work is needed.**

Corporate approach to overseeing strategic and corporate risks

- 83 We considered whether the Health Board has a sound corporate approach to identifying, overseeing, and scrutinising strategic risks to the delivery of strategic priorities / objectives. We were specifically looking for evidence of:
- an up-to-date and publicly available Board Assurance Framework (BAF) in place, which brings together all of the relevant information on the risks to achieving the organisation's strategic priorities / objectives; and
 - the Board actively owning, reviewing, updating, and using the BAF to oversee, scrutinise, and address strategic risks.

- 84 We found that **despite the Health Board's continued focus on refining the Board Assurance Framework and improving the content and sources of assurance, the Board still needs to clearly link its strategic risks to the strategic objectives within its Annual Plan.**
- 85 The Health Board continues to use its Strategic Risk and Assurance Report (Board Assurance Framework) to set out how it manages its strategic risks. The report continues to provide a clear summary of the Health Board's strategic risks. At the time of our work, there were eight high level strategic risks. Each of these risks had been scored according to the risk appetite of the Health Board. Executive Directors within the Health Board are assigned responsibility for strategic risks within their respective portfolios, and all risks are assigned to a responsible committee.
- 86 The Health Board is continuing to strengthen its strategic risk approach by undertaking assurance mapping and identifying 'lines of defence' (the assurances it needs for each strategic risk). However, the Board has not clearly linked its strategic risks to the strategic objectives in the current Annual Plan. Therefore, the Board is not able to clearly see the strategic risks that may prevent delivery of its objectives. **(Recommendation 8)**
- 87 Our 2023 Structured Assessment review found that the Health Board needed to address gaps in the Strategic Risk and Assurance Report and strengthen how it uses this to inform committee agenda setting. The Health Board has addressed these issues sufficiently (see **Appendix 2 Structured Assessment 2023, R4**). Since our last structured assessment, the Health Board has refreshed its Risk Management Framework and underpinning policy, which provides clear guidance around the risk escalation structure, and reporting thresholds. In support of the new framework, the Health Board is rolling out training to its operational teams to improve the identification, mitigation, and escalation of risk (see **Appendix 2 Structured Assessment 2023 R5**).
- 88 The Health Board is in the process of developing an approach for reporting and managing its corporate risks. The Health Board plans to update the Board by the end of the year on its progress.

Corporate approach to overseeing organisational performance

- 89 We considered whether the Health Board has a sound corporate approach to identifying, overseeing, and scrutinising organisational performance. We were specifically looking for evidence of:
- an appropriate, comprehensive, and up-to-date performance management framework in place, underpinned by clear roles and responsibilities; and
 - the Board and committees providing effective oversight and scrutiny of organisational performance.

- 90 We found that **the Health Board’s approach to performance management, accountability and oversight is improving, but there is further work to be done to improve performance reporting.**
- 91 The Health Board introduced its Performance Management and Accountability Framework in September 2023¹⁰. This focusses on service quality, performance, activity, workforce, and financial expectations and includes formal approaches for review and internal escalation. The operational divisions were originally assessed in November 2023, and subsequently reviewed in September 2024. The most recent reports indicate that:
- the Mental Health Division has been de-escalated from ‘special measures’ to ‘enhanced monitoring’, following improvements in leadership and delivering improvements in operational delivery and actions taken to address Health Inspectorate Wales recommendations
 - the Urgent Care Division has remained in ‘enhanced monitoring’ for quality and safety and delivery but de-escalated for finance.
- 92 This demonstrates that the Health Board is both using the framework effectively, and that the framework approach is currently an effective means for driving improvement.
- 93 In addition to the new divisional review approach, the Health Board has made broader progress in implementing the framework including:
- issuing Director accountability letters covering service deliverables, budget delivery, and individual objectives;
 - providing clearer expectations and milestones linked to the delivery of plans; and
 - strengthening the approach and reporting for quarterly review of outcomes.
- 94 The Health Board continues to experience significant service pressures which means that performance against key Welsh Government performance measures is below target. The Health Board will need to ensure that its performance framework approach secures the necessary operational improvements, alongside the longer-term strategic service modelling needed to develop sustainable services.
- 95 Our 2022 and 2023 Structured Assessment reports highlighted opportunities to improve the Integrated Performance Dashboard. The Health Board has since strengthened its performance reporting to Board. Performance reports are divided up into four sections (quality, workforce, activity/performance, and finance). The responsible Executive Director presents each at public Board members. Key areas for improvement are summarised as well as the things that need to improve. However, whilst the performance reports show performance trends, there remains

¹⁰ The Health Board assesses each division against three domains (quality and safety, operational delivery and finance) and assigns an escalation status for each domain (supported autonomy, enhanced monitoring or special measures). A formal review is undertaken every 6 months.

a lack of benchmarking information with other health bodies, as well as a lack of focus on primary and community care performance. **(Recommendation 9)**

Corporate approach to tracking recommendations

- 96 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising systems for tracking progress to address audit and review recommendations and findings. We were specifically looking for evidence of:
- appropriate and effective systems in place for tracking responses to audit and other review recommendations and findings in a timely manner.
- 97 We found that **the Health Board continues to have effective arrangements for tracking recommendations, but further work is required to reduce the number of overdue recommendations.**
- 98 The Health Board continues to have reasonably effective arrangements for monitoring progress against internal audit, external audit, and Healthcare Inspectorate Wales recommendations. It continues to use two trackers, one for internal and external audit recommendations which is received by the Audit, Risk and Assurance Committee at each meeting. The Healthcare Inspectorate Wales recommendations are captured on a separate tracker, which is periodically reviewed at the Patient, Quality, Safety and Outcomes Committee. The Health Board has continued to make progress in addressing overdue recommendations, but further work is needed to address the 42 recommendations that remain overdue.
- 99 The Health Board recently approved a procedure to improve both:
- the quality of the management response to audit recommendations; and
 - clarity on the roles and responsibilities of the Executive Directors and the Audit, Risk and Assurance Committee in respect of audit tracking.

Appendix 1

Audit methods

Exhibit 2 below sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

Element of audit approach	Description
Observations	We observed Board meetings as well as meetings of the following committees: • Public Board; • Audit, Risk and Assurance Committee; • Patient Safety, Quality and Outcomes Committee; • Finance and Performance Committee; • People and Culture Committee; and • Partnerships, Population Health, and Planning Committee.

Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Board and Committee Terms of Reference, work programmes, agendas, papers, and minutes; • key governance documents, including Schemes of Delegation, Standing Orders, Standing Financial Instructions, Registers of Interest, and Registers of Gifts and Hospitality; • key organisational strategies and plans, including the IMTP; • key risk management documents, including the Board Assurance Framework and Corporate Risk Register; • key reports relating to organisational performance and finances; • Annual Report, including the Annual Governance Statement; • relevant policies and procedures; and • reports prepared by the Internal Audit Service, Health Inspectorate Wales, Local Counter-Fraud Service, and other relevant external bodies.

Interviews

We interviewed the following Senior Officers and Independent Members:

- Chair of the Health Board;
- Chief Executive;
- Director of Corporate Governance;
- Director of Strategy, Planning and Partnerships;
- Director of Public Health;
- Director of Finance and Procurement;
- Independent Member – Finance & Chair of the Audit, Risk and Assurance Committee;
- Independent Member – Chair of the Patient Safety, Quality and Outcomes Committee; and
- Independent member – Chair of the Finance and Performance Committee.

Appendix 2

Progress made on previous years recommendations

Exhibit 3 below sets out the progress made by the Health Board in implementing recommendations from previous structure assessment reports

Recommendation	Description of progress
Structured Assessment 2022 Quality of Information to Board and Committees R2 Information presented to Board and committees does not always provide the required assurance. Some papers are too long, detailed, and technical. Cover reports continue to follow an SBAR format, but there is variation in their use. The Health Board, therefore, should develop training and guidance for Health Board staff around the reporting expectations and quality of information presented to the Board and its committees.	The Health Board is in the process of procuring external training to support report writing to improve the quality. More detail is provided in paragraph 70 Our assessment on progress against the recommendation: Ongoing

Recommendation	Description of progress
Structured Assessment 2022 Performance Reporting R4 The Integrated Performance Report has remained unchanged for several years, and at present it doesn't clearly articulate the impact of past and ongoing improvement actions. The Health Board should strengthen this report to provide more information to Board and committees on the actions required to address underperformance or the impact of past actions taken.	We recognise the progress that the Health Board has made in this area. However, we made a similar recommendation in our 2023 Structured Assessment report. More detail is provided in paragraph 96. Our assessment on progress against the recommendation: Superseded by Structured Assessment 2024 Recommendation 6
Structured Assessment 2022 Clinical Futures Strategy and Long-Term Clinical Plan R5 The Clinical Futures Strategy has remained in place for over a decade, but the pressures the Health Board is facing have changed substantially in this time. The Health Board, therefore, should: a. Review the Clinical Futures Strategy to ensure it helps to shape financially and clinically sustainable service models; and b. Develop a detailed long-term clinical plan that underpins the Clinical Futures Strategy.	The Health Board's Clinical Futures Strategy has been extant for some time. At the time of our work, the Health Board was starting to consult on the new strategy that will replace this work. More detail is provided in paragraph 13. Our assessment on progress against this recommendation: Superseded by Structured Assessment 2024 Recommendation 1

Recommendation	Description of progress
Structured Assessment 2022 Schemes of Delegation R7 The Health Board's deteriorating financial position and deterioration in savings deliver indicates that stronger accountability for financial performance and delivery is required. The Health Board, therefore, should review its Scheme of Delegation to ensure it more strongly outlines delegated accountability for the budgetary position and achievement of financial efficiencies at and below executive levels.	The Health Board has continued to implement its performance management and accountability framework with updates reported though the finance and performance committee. Work has been undertaken to review the delegated limits for the Chair, CEO and executive directors, benchmarked across other Health Boards and a paper was approved at Board in September 2024 which approved these changes. This will then inform further detailed work on review of the scheme of delegation (to cover delegated limits and other responsibilities and delegated authorities). This includes mapping executive director delegated responsibilities to portfolios. More detail is provided in paragraph 42. We consider this recommendation: Ongoing
Structured Assessment 2023 Committee Transparency R1 The Health Board should provide more timely access to records of committee meetings. It could do this either by ensuring that it livestreams or publishes recording of its committee meetings, or alternatively it could publish	The Health Board is working towards Livestreaming of committees. A programme of work is underway to determine the most appropriate solution for this as well as the products needed to ensure effectiveness. More detail is provided in paragraph 56. We consider this recommendation: Ongoing

Recommendation	Description of progress
unconfirmed committee meeting minutes shortly after the meeting.	
Structured Assessment 2023 Quality of Information R2 The Health Board should develop training and guidance for Health Board staff around the reporting expectations and quality of information presented to the Board and its committees. R3 The Health Board should establish a robust quality assurance mechanism to review the quality of reports for its Board and committees.	R2 - At the time of our work the Health Board was in the process of securing externally facilitated report writing training for executive directors and senior managers. Following this the Health Board is planning to review its report and presentation templates as part of improving Board business effectiveness. More detail is provided in paragraph 70. We consider this recommendation: Ongoing R3 - During 2023-24 the Director of Corporate Governance implemented an organisational change process to build capacity and resilience in the Board Business function. Further work is planned on quality assuring reports as well as report writing training and revised templates. More detail is provided in paragraph 70. We consider this recommendation: Ongoing
Structured Assessment 2023	

Recommendation	Description of progress
Strategic / Corporate Risk Management R4 The Health Board needs to rapidly complete remaining work to identify and address assurance gaps on its Strategic Risk and Assurance report and ensure it is actively owned by the Board and inform committee agenda setting. R5 The Health Board needs to complete the remaining work on its Risk Management Strategy and effectively embed arrangements across the organisation to help it manage the significant finance, performance, and quality risks it faces.	R4 - The Health Board approved the revised Risk Management Framework, which features an enhanced escalation process. The template now includes detailed information on sources of assurance, any gaps in assurance and necessary actions to close the gaps. Risk is used to inform the agenda setting for committees. More detail is provided in paragraph 88. We consider this recommendation: Complete R5 - In January 2024 the Board approved the risk management framework and the underpinning policy. The Health Board have started training sessions with directorates and divisions and have more scheduled in the future. More detail is provided in paragraph 88. We consider this recommendation: Complete

Recommendation	Description of progress
Structured Assessment 2023 Integrated Performance Dashboard R6 In the Integrated Performance Dashboard, the Health Board should provide more information on the actions required to address underperformance, the impact of past actions taken and where appropriate include benchmarking with other health bodies. (High Priority)	The performance reports and quarterly reports have been refreshed to align with the annual plan outcomes and KPIs. These have been strengthened with the actions and plan for delivery over the next period. There remains work to improve the reporting on the Quality and People Strategy. This is discussed in more detail in paragraph 96. We consider this recommendation: Ongoing
Structured Assessment 2023 Integrated Medium-Term Plan Progress Report R7 The Health Board should strengthen the IMTP Progress Report to ensure that it can be used as an effective tool for monitoring progress against the delivery of its strategic objectives. By including up to date data, and clear narrative on the impact of past and ongoing improvement actions. (High Priority)	The quarterly outcomes report has been updated maintaining the balance between a mix of definitive progress measures, and population outcome measures. The new format also supports including the actions and plans to address underperformance in key areas. More detail is provided in paragraph 27. Our assessment on progress against the recommendation: Complete

Appendix 3

Management response to audit recommendations

Exhibit 4: Aneurin Bevan University Health Board response to our audit recommendations

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1.1	As part of its ongoing long-term strategy development, the Health Board should: R1.1 Ensure the organisation's new long-term strategy clearly defines the required sustainable service solutions and decisions for the medium to longer term. This should include a strong focus on	Population Health and Prevention will be at the heart of the organisation's new long-term strategy and have been core themes from the engagement period. The long-term strategy will set out a clear strategic direction for the organisation. It will provide clarity of long-term direction, long-term	June 2025- Strategy Publication	Director of Strategy, Planning and Partnerships

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	population health and prevention. (Paragraph 14)	outcomes and provide a framework for decision making to support the sustainability of the organisation. The long-term strategy will not set out specific service provisions however it will be supported by a number of plans. This will include the development of a refreshed clinical services plan for the organisation which will describe sustainable service solutions. Key to this will be the Strategic Outline Case for Nevill Hall Hospital which will be presented to the Board in May 2025.		
R1.2	Ensure there is comprehensive engagement with clinical and other staff across all domains of the organisations service provision to feed into the development of the new long-term strategy. (Paragraph 15)	Engagement with staff alongside the public has been core to the development of the new strategy. The engagement survey and materials were provided to all staff and over 40 face to face sessions	Completed December 2024	Director of Strategy, Planning and Partnerships

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		took place with staff at all levels. Sessions took place with all clinical and non-clinical teams through divisional meetings as well as at wider clinical forums. Alongside this open drop in sessions took place at all hospital sites to allow staff to provide their views.		
R1.3	Publish well-being objectives either alongside or within its new long-term strategy and ensure Well-being of Future Generations (2015) Act requirements are an integral part of the strategy. (Paragraph 16)	Refreshed well-being objectives will be the organisational objectives and will be set within the new long-term Strategy.	June 2025	Director of Strategy, Planning and Partnerships
R2	To enable more effective scrutiny of delivery of corporate plans and strategies, the Health Board should ensure that progress reports are clear and contain performance	Work is underway to develop report templates and supporting guidance setting out requirements and standards. Report writing training will also be delivered to senior teams	September 2025	Director of Corporate Governance

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	targets and comparative benchmarks, where possible. Reports should also contain clear progress against established milestones to aid scrutiny of progress. (Paragraph 28)	responsible for preparing board and committee papers.		
R3.1	To become financially sustainable in the longer-term, the Health Board should: R3.1 develop a detailed longer-term financial plan that is linked to the new long-term strategy currently in development and ensure progress against delivery is reported appropriately. (Paragraph 39)	The long-term financial plan will be developed alongside the long-term strategy and will triangulate service, workforce and financial aspects of the strategy once measures and metrics of change are clarified. This will be iterative to ensure clarity of affordability and outcome benefits expected.	June 2025	Director of Finance and Procurement

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R3.2	Develop a detailed route-map to support the delivery of the long- term strategy. (Paragraph 39)	As per recommendation 3.1, the financial plan will be developed alongside the service plan.	June 2025	Director of Finance and Procurement
R4.1	The Health Board should strengthen its oversight of Standing Financial Instruction and Single Tender Actions by: R4.1 introducing a self-assessment on Standing Financial Instruction compliance; (Paragraph 43) and	A self-assessment of Standing Financial Instructions will be established as part of the annual review at year end to the Audit, Risk and Assurance Committee.	March 2025	Director of Finance and Procurement
R4.2	R4.2 ensuring Single Tender Action reports include total contract values, setting out whether Board or Welsh Government approval was needed, and provide trend analysis of	Single Tender Action reporting will be updated to include these elements.	March 2025	Director of Finance and Procurement

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	numbers and total values of Single Tender Actions for comparative periods in previous years. (Paragraph 43)			
R5	To enable deeper scrutiny of operational finance and performance the Health Board should increase the frequency of the finance and performance committee meetings. (Paragraph 48)	The 2025/26 Committee Planner has established meetings of the Finance and Performance Committee to be held bi-monthly as opposed to quarterly.	Complete	Director of Corporate Governance
R6	The Health Board should ensure there is effective separation of responsibilities between the role of the Health Board Chair and the Chair of the Partnerships, Population Health and Planning Committee. The Health Board should seek to appoint a separate committee chair from the	In 2025/26 the Partnerships, Population Health and Planning Committee will be chaired by the Vice Chair.	April 2025	Director of Corporate Governance

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	wider cohort of independent members. (Paragraph 64).			
R7	The Health Board needs to allow sufficient time on Board meeting agendas for the committee chairs to report assurance to the Board and escalate any concerns. (Paragraph 67)	The format of committee chair reports to the Board will be reviewed to ensure clarity on escalation of issues that require the Board's attention whilst balancing the need to ensure the Board does not duplicate the work of its committees.	September 2025	Director of Corporate Governance
R8	The Health Board should ensure there is a clear approach that links the strategic risks in its risk register to the strategic objectives in its annual plan. (Paragraph 86)	The Strategic Risk Register will be reviewed and updated to ensure alignment of risks with the objectives of the IMTP and Annual Plan 2025/26.	April 2025	Director of Corporate Governance
R9	The Health Board should ensure there is a stronger focus on primary and community care performance	The Health Board acknowledges the recommendation and has included in the 2025/26 Planning Process is a	June 2025	Director of Strategy,

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	within its Integrated Performance reports. (Paragraph 95)	stronger focus on Building Community Capacity and Population Health and Prevention aligned with the Ministerial Delivery Expectations. As part of the 2025/26 Plan and update of the Integrated Quarterly report, measures will be included for: • Vaccinations, • Diabetes recommended care process delivery • Delayed Pathways of Care, • Access standards • Dental access, • Community nursing and palliative care resource levels • Enhanced Community Care These are alongside the Primary Care Minimum Data set measures which also include Optometry and GMS and the Health Board Priorities for:		Planning and Partnerships

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		• Transforming Community Services, • NCN and Place Based Care, • Premature Preventable Mortality • Facilitating early Discharge		



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

Annual Audit Report 2024 – Aneurin Bevan University Health Board

Audit year: 2023-24

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Summary report

About this report

- 1 This report summarises the findings from my 2024 audit work at Aneurin Bevan University Health Board (the Health Board) undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004. That Act requires me to:
 - examine and certify the accounts submitted to me by the [Health Board/Trust/Special Health Authority], and to lay them before the Senedd;
 - satisfy myself that expenditure and income have been applied to the purposes intended and are in accordance with authorities; and
 - satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources.
- 2 I report my overall findings under the following headings:
 - Audit of accounts
 - Arrangements for securing economy, efficiency, and effectiveness in the use of resources
- 3 This year's audit work took place at a time when NHS bodies were continuing to respond to a broad set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. In addition, NHS bodies are still dealing with the legacy of the COVID-19 pandemic. My work programme, therefore, was designed to best assure the people of Wales that public funds are well managed.
- 4 We largely continued to work and engage remotely where possible through the use of technology, but some on-site audit work resumed where it was appropriate to do so. This inevitably had an impact on how we deliver audit work but has also helped to embed positive changes in our ways of working.
- 5 The audited accounts submission deadline was shortened by two weeks from the previous year to 15 July 2024. The financial statements were certified on 12 July 2024, meaning the deadline was met. This reflects a great collective effort by both my staff and the Health Board's officers.
- 6 The focus and approach of my performance audit work continues to be aligned to the post-pandemic challenges facing the NHS in Wales and is conducted in line with INTOSAI¹ auditing standards.
- 7 This report is a summary of the issues presented in more detailed reports to the Health Board this year (see **Appendix 1**). I also include a summary of the status of work still underway, but not yet completed.

¹ INTOSAI (International Organisation of Supreme Audit Institutions) 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.

- 8 **Appendix 2** presents the latest estimate of the audit fee that I will need to charge to cover the costs of undertaking my work, compared to the original fee set out in the 2024 Audit Plan.
- 9 **Appendix 3** sets out the audit of accounts risks set out in my 2024 Audit Plan and how they were addressed through the audit.
- 10 The Chief Executive and the Director of Finance have agreed the factual accuracy of this report. We presented it to the Audit Committee on 18 February 2025. The Board will receive the report at a later Board meeting. We strongly encourage the Health Board to arrange its wider publication. We will make the report available to the public on the [Audit Wales website](#) after the Board have considered it.
- 11 I would like to thank the Health Board's staff and members for their help and co-operation throughout my audit.

Key messages

Audit of accounts

- 12 I concluded that the Health Board's accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them. My work did not identify any material weaknesses in internal controls (as relevant to my audit) however, I brought some issues to the attention of officers and the Audit and Risk Assurance Committee for improvement.
- 13 The Health Board did not achieve financial balance for the three-year period ending 31 March 2024, which I deem to be outside its powers to spend, so I have issued a qualified opinion on the regularity of the financial transactions within the Health Board's 2023-24 accounts.
- 14 Alongside my audit opinion, I placed a substantive report on the Health Board's accounts to highlight the failure to achieve financial balance and the failure to have an approved three-year plan in place.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

- 15 My programme of Performance Audit work has led me to draw the following conclusions:
- whilst the Health Board did not achieve its deficit control total or savings target for 2023-24, it delivered significantly more savings than in prior years. However, given its financial position remains very challenging the Health Board urgently needs to develop a longer-term financial plan focused on achieving recurrent savings from transformational service change, and further embed its savings approach through its Value and Sustainability Board.

- the Health Board's board and committee governance arrangements are stable and generally effective. However, given its financial and performance challenges, the development of a new long-term strategy and delivery of its three-year "route map" are crucial to enabling the organisation to transform services to meet current and future demand.
- despite a clear focus on improving patient flow within the region, a significant number of medically fit patients are occupying hospital beds. This continues to have serious knock-on effects on other NHS pathways of care and creates risks for patients' physical and mental well-being. More timely assessments of patients, a less risk averse approach to discharge planning and more consistent application of discharge policy is needed. Workforce and IT system challenges continue to be key barriers that partners will need to focus on securing value from the investments they have made and to achieving the improvements they recognise are needed.
- There has been mixed progress against my previous recommendations on discharge planning with only two out of seven being fully implemented.

16 These findings are considered further in the following sections.

Detailed report

Audit of accounts

- 17
- Preparing annual accounts is an essential part of demonstrating the stewardship of public money. The accounts show the organisation’s financial performance and set out its net assets, net operating costs, gains and losses, and cash flows. My annual audit of those accounts provides an opinion on both their accuracy and the proper use (‘regularity’) of public monies.
- 18
- My 2024 Audit Plan set out the key risks for audit of the accounts for 2023-24 and these are detailed along with how they were addressed in **Exhibit 4, Appendix 3**.
- 19
- My responsibilities in auditing the accounts are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

Accuracy and preparation of the 2023-24 accounts

- 20
- I concluded that the Health Board’s accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them. My work did not identify any material weaknesses in internal controls (as relevant to my audit) however, I brought some issues to the attention of officers and the Audit and Risk Assurance Committee for improvement.
- 21
- I must report issues arising from my work to those charged with governance (the Audit and Risk Assurance Committee) for consideration before I issue my audit opinion on the accounts. My Financial Audit Manager reported these issues on 9 July 2024. **Exhibit 1** summarises the key issues set out in that report.

Exhibit 1: issues reported to the Audit Committee

Issue	Auditors’ comments
Uncorrected misstatements	There were no corrected misstatements
Corrected misstatements	There were a number of adjustments made to the draft accounts, the net effect of which was to increase the deficit by £12k.
Other significant issues	I qualified my regularity opinion and issued a substantive report because the Health Board did not achieve its financial duty to achieve financial balance for the three-years 2021-22 to 2023-24.

- 22 I also undertook a review of the Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the Health Board's financial position on 31 March 2024 and the return was prepared in accordance with the Treasury's instructions.
- 23 My separate audit of the charitable funds accounts is nearing completion and scheduled to be reported to trustees on 22 January 2025.

Regularity of financial transactions

- 24 The Health Board's financial transactions must be in accordance with authorities that govern them. The Health Board must have the powers to receive income and incur expenditure. My work reviews these powers and tests that there are no material elements of income or expenditure which the Health Board does not have the powers to receive or incur.
- 25 Where a Health Board does not achieve financial balance, its expenditure exceeds its powers to spend and so I must qualify my regularity opinion.
- 26 The Health Board did not achieve financial balance for the three-year period ending 31 March 2024, which I deem to be outside its powers to spend, so I have issued a qualified opinion on the regularity of the financial transactions within the Health Board's 2023-24 accounts.
- 27 In 2023-24 the Health Board exceeded its revenue resource allocation by £49.766 million and over the three-year period 2021-22 to 2023-24, the Health Board exceeded its cumulative revenue resource limit of £5,007.912 million by £86.359 million.
- 28 Alongside my audit opinion, I placed a substantive report on the Health Board's accounts to highlight the failure to achieve financial balance and the failure to have an approved three-year plan in place.
- 29 I have the power to place a substantive report on the Health Board's accounts alongside my opinions where I want to highlight issues. Due to the issues set out above, I issued a substantive report setting out the factual details.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

- 30 I have a statutory requirement to satisfy myself that Health Board has proper arrangements in place to secure efficiency, effectiveness, and economy in the use of resources. I have undertaken a range of performance audit work at the Health Board over the last 12 months to help me discharge that responsibility. This work has involved:
- reviewing the effectiveness of the Health Board's cost savings arrangements; and

- undertaking a structured assessment of the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically;
- reviewing the effectiveness of the Health Board's arrangements, in partnership with social services, to support timely patient flow out of hospital across the Region; and
- assessing the extent to which the Health Board has implemented my 2017 recommendations on discharge planning.

31 My conclusions based on this work are set out below.

Review of cost savings arrangements

32 My review examined whether the Health Board has an effective approach to identifying, delivering, and monitoring sustainable cost savings opportunities. It considered the impact these arrangements had on the Health Board's 2023-24 year-end position and highlighted where arrangements may need to be strengthened for 2024-25 and beyond.

33 My work found that **whilst the Health Board did not achieve its deficit control total or savings target for 2023-24, it delivered significantly more savings than in prior years. However, given its financial position remains very challenging the Health Board urgently needs to develop a longer-term financial plan focused on achieving recurrent savings from transformational service change, and further embed its savings approach through its Value and Sustainability Board.**

34 The Health Board has clear arrangements in place for identifying and analysing the areas that are driving its costs in the short- to medium-term. This includes but is not limited to variable (temporary) staff pay costs, Continuing Health Care, prescribing, energy, delayed transfers of care, growth in demand for services and capacity challenges. The Health Board uses evidence from a wide range of data sources to analyse and identify savings opportunities. This is a key element of the work of the Health Board's Value and Sustainability Board, which meets fortnightly to consider progress across defined savings workstreams (such as workforce, medicines management, and service redesign) using data from external intelligence sources, independent reviews, and audits. The identified opportunities are captured within the Health Board's Compendium², which provides a central repository for identifying and monitoring progress on both national and local savings opportunities.

35 The Health Board's Value and Sustainability Board provides oversees the organisation's arrangements for identifying and assessing the quality implications of savings schemes. The Health Board is also developing other mechanisms to assess impact, risks, and benefits for savings schemes that require investment,

² Compendium - Is the Health Board's repository for savings and efficiency ideas and initiatives, drawn from a wide variety of sources.

such as its Pre-Investment Panel. Despite these defined processes, there is an inconsistency in the extent to which they have been routinely applied across all identified savings schemes. The Health Board has made some positive initial steps to develop a short-medium term financial plan. In July 2024, it approved a three-year route map which aims to achieve its £13 million control total by 2025-26 and deliver financial balance by 2026-27. The Health Board has also invested in developing financial skills and capabilities to support its savings delivery; however, there is scope to increase finance training for managers and leaders.

- 36 The Health Board has well-developed arrangements in place for monitoring the delivery of savings. The finance reports, which form the basis of its savings reporting, provide both a summary of progress against the key cost drivers and granular detail on savings performance across the divisions and directorates within in the report's appendices. However, there needs to be greater focus on the delivery and barriers getting in the way of longer-term transformational savings.

Structured assessment

- 37 My 2024 structured assessment work took place at a time when NHS bodies were continuing to respond to a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. In addition, NHS bodies are still dealing with the legacy of the COVID-19 pandemic. More than ever, therefore, NHS bodies and their Boards need to have sound corporate governance arrangements that can provide assurance to themselves, the public, and key stakeholders that the necessary action is being taken to deliver high-quality, safe and responsive services, and that public money is being spent wisely.
- 38 My team focussed on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on: Board transparency, effectiveness, and cohesion; corporate systems of assurance; corporate approach to planning; and corporate approach to managing financial resources. Auditors also paid attention to progress made to address previous recommendations.
- 39 At the time of my structured assessment work, the Health Board was subject to escalation under the Welsh Government's escalation and intervention arrangements. The position as of November 2023, is that the Health Board is escalated to Level 4 for finance, strategy and planning and Level 3 for performance and outcomes related to urgent and emergency care pathways at The Grange University hospital emergency department.

Corporate approach to planning

- 40 My work considered whether the Health Board has a sound corporate approach to planning. I paid particular attention to the organisation's arrangements for:
- producing and overseeing the development of strategies and corporate plans, including the Integrated Medium-Term Plan; and

- overseeing the delivery of corporate strategies and plans.

- 41 My work found that **Health Board's approach to developing and delivering strategic plans is reasonably effective. However, the approach is not yet enabling it to deliver sustainable services that meet demand. As a result, it is imperative that its ongoing long-term strategy development provides the basis and ambition for planning and transforming services that meet current and future needs.**
- 42 The Health Board's extant Clinical Futures Strategy has helped guide service sustainable developments and supporting infrastructure. However, the Health Board is facing performance and financial challenges which means that it is struggling to sustainably meet population health needs. The development of a new long-term strategy is a clear priority for the Health Board, which it intends to publish in 2025. This will need to effectively consider and embed the requirements of the Wellbeing of Future Generations (Wales) Act 2015 and include a review of the organisation's wellbeing objectives. The Health Board also demonstrates generally effective arrangements for developing strategic plans built on good engagement.
- 43 The Health Board is working to an Annual Plan for 2024-25 as it was unable to submit an approvable, financially balanced Integrated Medium-Term Plan for 2024-27 to Welsh Government. The Health Board received some challenge from Welsh Government on the draft annual plan requiring it to demonstrate greater ambition for improvement and service recovery. Quarterly IMTP progress reporting has improved but reports on the progress of some of the Health Board's other key plans are sometimes difficult to read and gain assurance from.

Corporate approach to managing financial resources

- 44 My work considered whether the has a sound corporate approach to managing its financial resources. I paid particular attention to the organisation's arrangements for:
- achieving its financial objectives;
 - overseeing financial planning;
 - overseeing financial management; and
 - overseeing financial performance.
- 45 My work found that **Health Board is improving its financial controls and has a stronger focus on value and savings delivery. However, its significant and ongoing financial challenges suggest that it needs a longer-term and detailed financial strategy aligned to sustainable care models.**
- 46 Despite additional funding from Welsh Government, the Health Board did not meet its key financial objectives and duties for 2023-24. In December 2024, the Welsh Government announced a further additional £40.5 million allocation³, which if

³ £9.5 million is recurring and £31 million will be recurring funding if the Health Board achieves the conditions set out in its allocation letter.

certain conditions are met, could result in this funding becoming recurring. This will help the Health Board substantially in the current year and could help to reduce the underlying deficit in future years. However, because the Health Board is required to achieve a rolling three-year breakeven position, its historical financial deficit will make it unlikely to achieve its key financial revenue targets for 2022-25.

- 47 The Health Board has improving arrangements for Board and committee oversight of financial planning. While there is improving engagement and oversight of financial planning, there is a clear need to develop a longer-term financial recovery plan linked to the emerging long-term strategy and three-year financial route-map.
- 48 The Health Board has strengthened its structures and resources to support divisional savings delivery and there is stronger accountability and shared ownership for savings led by the bi-weekly Value and Sustainability Board.
- 49 The Board reviews Standing Orders and Standing Financial Instructions frequently and its committees appropriately oversee and scrutinise financial performance, with finance reports providing sufficient information to enable appropriate scrutiny and oversight. Reports are transparent and supported by detailed explanation from the relevant Executive leads. The Audit, Risk and Assurance Committee gain a wide range of assurances on financial compliance, the programme of internal audit and counter fraud work. However, Standing Financial Instruction compliance and single tender actions monitoring could be strengthened.

Board transparency, effectiveness, and cohesion

- 50 My work considered whether the Health Board's Board conducts its business appropriately, effectively, and transparently. I paid particular attention to:
- Public transparency of Board business
 - Arrangements to support the conduct of Board business
 - Board and committee structure, business, meetings, and flows of assurance
 - Board commitment to hearing from staff, users, other stakeholders
 - Board skills, experiences, cohesiveness, and commitment to improvement
- 51 My work found that **despite reasonably effective Board and committee arrangements, the Health Board should, increase the number of patient safety leadership walkarounds, and improve committee chairs' reporting to Board.**
- 52 The Board and committee structure is generally operating well. Board and committees continue to operate transparently with open discussion on key Health Board challenges. Board members hold open and frank discussions on the Health Board's performance, finance, and quality challenges. Meetings are well chaired and there are reasonably effective arrangements in place to support flows of assurance from committees to the Board and the referral of information between committees. However, the Health Board could strengthen arrangements for committees to formally escalate issues to the Board.

- 53 Board and committee papers are generally clear and support effective decision making. The Health Board has increased capacity within the Corporate Governance Team this year, which has enabled improvements. This includes developing the new Risk Management Framework and updating other important policies. It estimates that around 55% of its policies are out of date, however, there is targeted work ongoing both to remedy the position and to determine the status and need for all these policies.
- 54 The Board is cohesive and committed to continuous improvement, with good Board member induction and training opportunities. The Board has a stable cadre of Independent Members with good lines of communication and awareness of respective roles and responsibilities amongst its members. It also continues to demonstrate a positive commitment to hearing from staff and patients. However, it needs to improve Patient Safety Leadership Walkarounds. Between May 2023 and October 2024, only a third of the pre-arranged visits took place.

Corporate systems of assurance

- 55 My work considered whether the Health Board has a sound corporate approach to managing risks, performance, and the quality and safety of services. I paid particular attention to the organisation's arrangements for:
- overseeing strategic and corporate risks;
 - overseeing organisational performance;
 - overseeing the quality and safety of services; and
 - tracking recommendations.
- 56 My work found that **while the Health Board is strengthening its assurance arrangements and its performance management approach is improving, further work is needed.**
- 57 Despite the Health Board's continued focus on refining the Board Assurance Framework, the Board still needs to more clearly link its strategic risks to the strategic objectives within its Annual Plan. The Health Board is continuing to strengthen its strategic risk approach by undertaking assurance mapping and identifying the assurances it needs for each strategic risk.
- The Health Board's approach to performance management, accountability and oversight is improving. The Health Board introduced its Performance Management and Accountability Framework in September 2023, and it is demonstrating that it is appropriately using its approach to review and escalate (or de-escalate) services based on their performance.
- The Health Board continues to have reasonably effective arrangements for monitoring progress against internal audit, external audit, and Healthcare Inspectorate Wales recommendations.

Urgent and emergency care

- 58 My work examined different aspects of the urgent and emergency care system focused on patient flow out of hospital, progress against my previous discharge planning recommendations, and arrangements for managing demand. My work on arrangements for managing demand is due to be reported in May 2025 and will therefore be captured in next year's Annual Audit Report.

Patient flow out of hospital

- 59 My regional review examined whether the Health Board and its social services partners have effective arrangements to ensure the timely discharge of patients out of hospital. It focussed on the scale of the challenge, and the factors impacting on effective and timely flow out of hospital. My work also considered the action being taken by the Health Board and its statutory partners, including through the Regional Partnership Board, and what more can be done to reduce some of the challenges currently being experienced by the health and social care system.
- 60 My work found that **despite a clear focus on improving patient flow within the region, a significant number of medically fit patients are occupying hospital beds. This continues to have serious knock-on effects on other NHS pathways of care and creates risks for patients' physical and mental well-being. More timely assessments of patients, a less risk averse approach to discharge planning and more consistent application of discharge policy is needed. Workforce and IT system challenges continue to be key barriers that partners will need to focus on securing value from the investments they have made and achieving the improvements they recognise are needed.**
- 61 For the twelve months up to and including February 2024, each month there were an average of 250 medically fit patients in the Health Board's hospitals whose discharge was delayed equating to 55,685 bed days lost and potential resource loss of £27.8 million. The consequent impact on patient flow within hospitals and the urgent and emergency care system is significant, with waiting times in emergency departments and ambulance handovers falling well short of national targets. In February 2024, there were over 3,000 lost ambulance hours because of handover delays, and the average wait within the Health Board's emergency department was 8.5 hours.
- 62 Several factors are contributing to delayed discharges. Complexity and volume of demand is increasing in line with an ageing population, but the pressures may be exacerbated by being risk averse to or delays in patient discharge. Workforce capacity in both health and social care is a challenge for the region, impacting on joint and clinical assessments, although waits for social care assessments are less problematic than many other parts of Wales, and the care sector capacity across the region is generally meeting demand.
- 63 Financial resources are being targeted to support patient flow with positive outcomes, although the ability of the partners to match fund is increasingly challenging. There is clear oversight and scrutiny of actions being taken to improve

patient flow, although more could be done to gather patient and service user feedback and oversee compliance with current discharge policies. However, there is a clear recognition by regional partners of the problems associated with discharge, the number of delayed discharges across the region have not significantly reduced.

Discharge planning: progress update

- 64 In undertaking my regional review of arrangements to support patient flow, I have also taken the opportunity to consider progress made by the Health Board in addressing my previous 2017 recommendations relating to discharge planning.
- 65 My work found that there has **been mixed progress against my previous recommendations**. My 2017 report made four recommendations that set out seven specific actions for the Health Board. Noting that the Health Board had accepted these recommendations, my follow up work found that:
- no progress has been made against one of the actions;
 - work is still ongoing against four of the actions; and
 - two of the actions have been implemented.
- 66 The Health Board has made progress developing supporting tools for discharge, but these have not been developed with partners and the communication and monitoring of the tools needs improving. For example, it has developed a discharge policy but has missed the opportunity to develop an integrated approach across partners. I found clear guidance setting out when patient transport should be used. However, there is a lack of awareness of the transport booking policy and communicating predicted waiting times continues to be reliant on local arrangements.
- 67 The Health Board has taken steps to improve its staff induction training in relation to discharge but needs to go further to improve refresher training and embed joint training with other partners. The Health Board's corporate induction programme includes the discharge policy, and discharge planning training is provided to all newly registered nurses along with competency checks and ad-hoc training for new starters. However, the Health Board's programme of refresher training on discharge planning was impacted by the pandemic and further work is required to ensure that this training is consistently implemented across each hospital site.
- 68 There is no access for health staff to up to-date information about waiting times for needs assessments or services to commence, although there are examples of positive integrated working which provide information on a case-by-case basis. In addition, many staff are unaware of the complete range of community-based services that can support discharge planning and the associated waiting times for those services to commence.

Appendix 1

Reports issued since my last annual audit report

Exhibit 2: reports issued since my last annual audit report

The following table lists the reports issued to the Health Board in 2024.

Report	Date
Financial audit reports	
Audit of Financial Statements Report	July 2024
Opinion on the Financial Statements	July 2024
Audit of Accounts Report Addendum	October 2024
Audit of Charitable Funds Audit of Financial Statements Report and Opinion of the Financial Statements	January 2025
Performance audit reports	
Structured Assessment 2024	December 2024
Review of Cost Savings Arrangements	December 2024
Unscheduled Care: Flow out of Hospital	January 2025
Discharge Planning: Progress Update	January 2025
Other	

Report	Date
2024 Audit Plan	April 2024

My wider programme of national value-for-money studies in 2024 included reviews that focused on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts Committee to support its scrutiny of public expenditure. Reports are available on the [Audit Wales website](#).

Exhibit 3: performance audit work still underway

There are several performance audits that are still underway at the Health Board. These are shown in the following table, with the estimated dates for completion of the work.

Report	Estimated completion date
Review of Quality Governance	March 2025
Review of Planned Care Services Recovery	March 2025
Eye care services	April 2025
Urgent and Emergency Care – Arrangements for Managing Demand	June 2025
Review of Digital Transformation	June 2025

Appendix 2

Audit fee

The 2024 Audit Plan set out the proposed audit fee of £454,611 (excluding VAT). My latest estimate of the actual fee, on the basis that some work remains in progress, is that there will be a refund on the accounts work. This is currently being finalised and we will update the Director of Finance once completed.

Appendix 3

Audit of accounts risks

Exhibit 4: audit of accounts risks

My 2024 Audit Plan set out the risks of material misstatement and/or irregularity for the audit of the Health Board’s 2023-24 accounts. The table below lists these risks and sets out how they were addressed as part of the audit.

Audit risk	Proposed audit response	Work done and outcome
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.	No material issues arose from the work completed.
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.	My audit team reviewed year-end transactions, in particular accruals and cut-off. No matters arose from the work carried out. I chose to place a substantive report on the financial statements explaining the failure to break even over a three period and the circumstances under which it arose.

Audit risk	Proposed audit response	Work done and outcome
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 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 excel model miscalculating balances, due to spreadsheet/modelling errors and/or incorrect data entry.	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.	No material issues arose from the work completed.
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	Our work in this area identified some issues relating to both related parties and the remuneration report. These were reported to those charged with governance in the Audit of Accounts report prior to the accounts being approved and signed off.

Audit risk	Proposed audit response	Work done and outcome
	appropriately and accurately.	
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.	No material issues arose from the work completed.
Provisions and contingent liabilities are measured as 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.	No material issues arose from the work completed.



Audit Wales

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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.

Aneurin Bevan University Health Board

Outline Audit Plan 2025

Audit year: 2024-25

Date issued: January 2025

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.



This document has been prepared as part of work performed in accordance with statutory functions. Further information can be found in our [Statement of Responsibilities](#).

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. Audit Wales is not a legal entity and itself does not have any functions.

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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.

About Audit Wales

Our aims:

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

Our ambitions:



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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Fees and audit team	7
Audit timeline	8
Audit quality	9

Introduction

This Outline Audit Plan specifies my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice. It also sets out details of my audit team and key dates for delivering my audit team's activities and planned outputs. I intend to share a Detailed Audit Plan later in the year following the completion of my planning work. It will set out my estimated audit fee and the work my team intends to undertake to address the audit risks identified and other key areas of audit focus during 2025.



Adrian Crompton
Auditor General for
Wales

My audit responsibilities

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 will be reported to you in my Detailed Audit 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.

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.

Fees and audit team

In January 2025 I published the fee scheme for the year, approved by the Senedd Finance Committee. This sets out my fee rates. My fee rates for 2025-26 have increased by an average of 1.7% because of unavoidable inflationary pressures.

I will provide an estimate of your fee in my Detailed Audit Plan in April 2025, following completion of my detailed risk assessment.

Your engagement team:

Richard Harries	Engagement Director & Audit Director (Financial Audit)
Dave Thomas	Audit Director (Financial Audit)
Julie Rees	Audit Manager (Financial Audit)
Andrew Doughton	Audit Manager (Performance Audit)
Angharad Clemens	Audit Lead (Financial Audit)
Sara Utley	Audit Lead (Performance Audit)

We confirm that our audit team members are all independent of the Health Board and your officers.

Audit timeline

We set out below key dates for delivery of our audit work and planned outputs.

Planned output	Work undertaken	Report finalised
2025 Outline Audit Plan	January - February 2025	February 2025
2025 Detailed Audit Plan	February – April 2025	April 2025
Audit of financial statements work: • Audit of Financial Statements Report • Opinion on the Financial Statements.	May – June 2025	June 2025
Performance audit work: • Structured Assessment, incorporating a deeper dive into estates management. • All-Wales thematic review of cancer services, following on from my national report on the strategic leadership of cancer services in Wales. • In terms of local project work, my early planning work suggests there would be value in reviewing the effectiveness of operational risk management arrangements, with a particular consideration of service risk, capital project risk and partnership risk management. However, my planning work might also highlight other areas worthy of review. Therefore, the exact focus of my local project work will be confirmed in my detailed Audit Plan in April 2025.	Timescales for individual projects will be discussed with you and detailed within the specific project briefings produced for each study.	

Audit quality

My commitment to audit quality in Audit Wales is absolute.

I 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 QAD¹ and our Chair acts as a link to our Board on audit quality. For more information see our [Audit Quality Report 2024](#).



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

¹ QAD is the Quality Assurance Department of ICAEW.



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	18 February 2025
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Development of the Annual Report 2024/25
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

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.

This paper outlines the requirements of the Annual Report and Accounts 2024/25, and the key contributors in the development of these reports.

The Health Board received the DRAFT Manual for Accounts on the 17th December 2024, outlining the draft reporting deadlines.

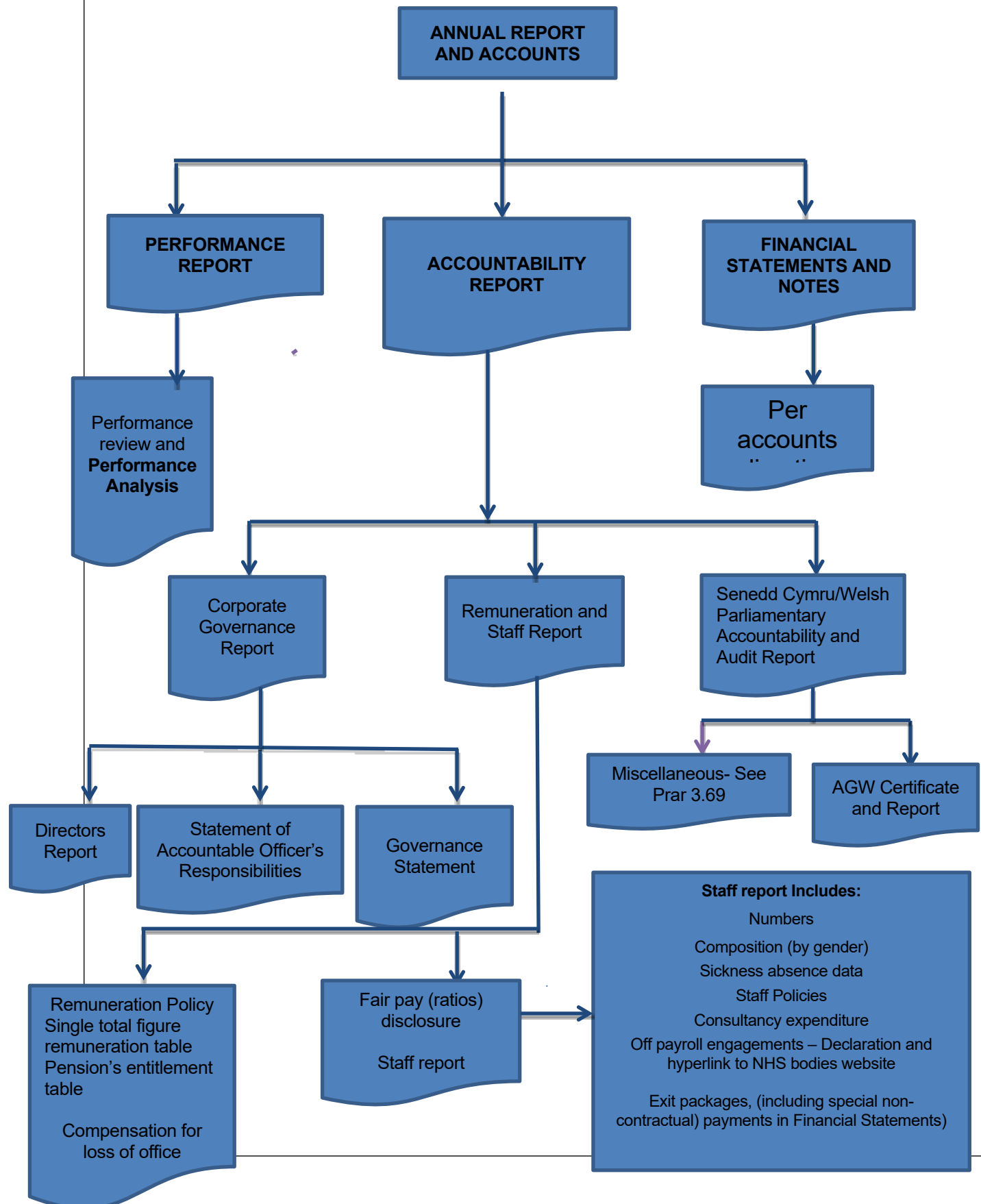
Cefndir / Background

NHS bodies are 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 2024/25.

Annual Report and Accounts Outline Structure



Asesiad / Assessment

It is proposed that the development of the different sections of the Annual Report are led as follows:

- Performance Report – Director of Strategy, Planning and Partnerships
- Accountability Report – Director of Corporate Governance
- Remuneration Report – Director of Corporate Governance and Director of Finance
- Annual Accounts – Director of Finance

As highlighted earlier in this report, the final Manual for Accounts is awaited, however, Audit Wales have confirmed the certification deadline. The timetable for submission is outlined below:

Annual Reports 2024/25 - Key Dates	2025	
Draft Accounts to WG	Fri	2-May
Draft Reports to ARA Committee Members	Thurs	8-May
Draft Performance Report Overview, Accountability Report and Remuneration Report to WG	Tues	13-May
ARA Committee meeting to Consider Draft Accounts and Draft Accountability Report	Tues	20-May
Final Accounts & Accountability Report to Audit Committee Members	Tues	17-June
ARA Committee meeting to Consider Final Accounts, and Accountability Report	Tues	24-June
Board meeting to approve Final Accounts and Accountability Report	Wed	25-June
Certification by Auditor General		
Final Annual Report Deadline for Submission to WG – Annual Report and Accounts as a single unified document	Mon	30 June
Annual General Meeting – to receive the Annual Report and Accounts	Wed	24 Sept

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is requested to:

- Note the requirement to prepare a 3 part Annual Report 2024/25;
- Note the timescales for submission;
- Note that the final Manual for Accounts is awaited

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.