Supporting Appendices

Tue 02 August 2022, 09:30 - 12:30

Agenda

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1. Item 2.2 Audit Recommendations Tracker Appendices A-F

Attachment *Director of Corporate Governance*

Both procedure documents have had changes highlighted in yellow.

- 2.2a Appendix A_Audit Recc Tracker_IA_EA_March22_MASTER_30Ju.pdf (3 pages)
- 2.2b Appendix B_Internal Audit Recc_OVERDUE_30April22.pdf (1 pages)
- 2.2c Appendix C_Internal Audit Recc_PROPOSED REVISED DAT.pdf (1 pages)
- 2.2d Appendix D_Internal Audit Recc_COMPLETED_30April22.pdf (1 pages)
- 2.2e Appendix E_Internal and External Audit Recc_NOT Y.pdf (1 pages)
- 2.2f Appendix F_External Audit Recc_OVERDUE_30April22.pdf (1 pages)

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2. Item 3.1: Governance Report Financial Control Procedures Appendices 1 & 2

Attachment *Assistant Director of Finance*

- 3.1a Appendix 1 ABUHB_Finance_0559 Recovery of Overpayments to Employees_Issue 5 Final (002).pdf (22 pages)
- 3.1b Appendix 2 ABUHB_Finance_0241 FCP Budgetary Control_Issue Final.pdf (22 pages)

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3. Item 7: For Information

Attachment *Director of Corporate Governance*

3.1. Audit Wales ambitious new five year strategy ‘Assure, Explain, Inspire’

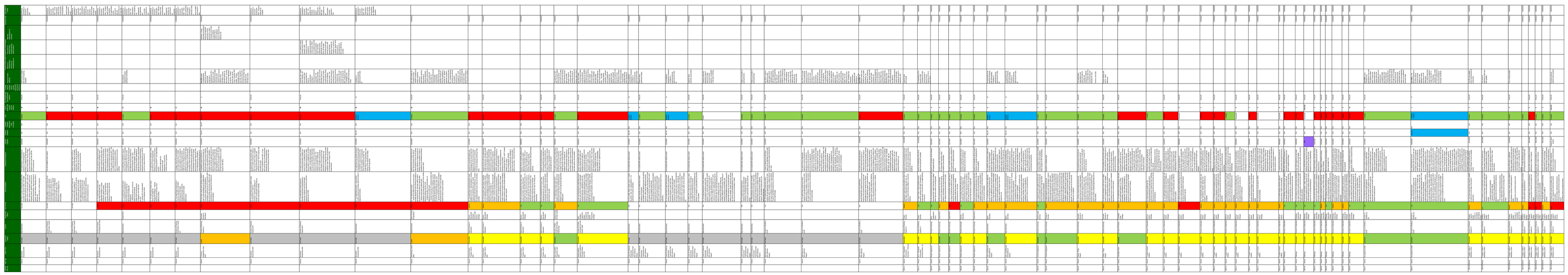
- 7.1b Audit-Wales-Strategy-Assure_Explain_Inspire 2022-2027.pdf (16 pages)

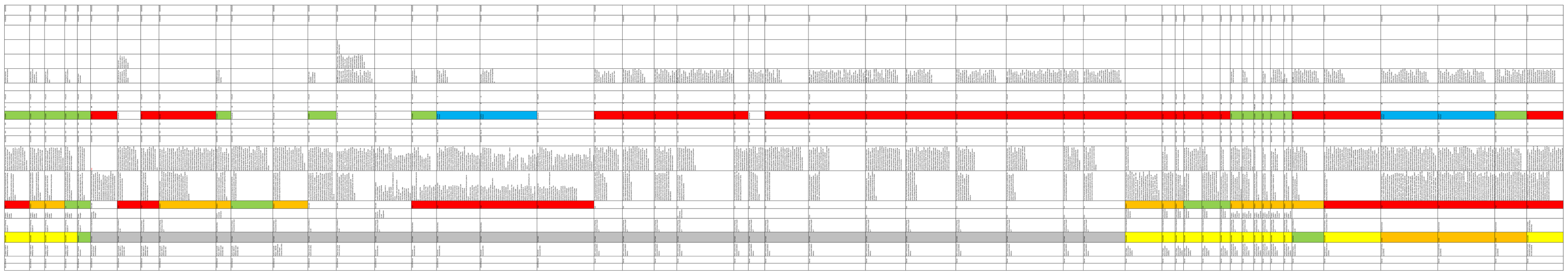
3.2. Welsh Community Care Information System

- 7.2 WCCIS-Letter_to_MS_Chair_PAPAC.pdf (18 pages)

3.3. Tackling the Planned Care Backlog in NHS Wales

- 7.3 2022-06-24 - JP to Adrian Crompton AGW - response to Audit Wales report on tackling the planned care backlog.pdf (3 pages)
- 7.3a Tackling_the_Planned_Care_Backlog_in_Wales.pdf (30 pages)





	Internal	Health and Safety (2017/18)	Limited	Director of Therapies & Health Science	Head of Health and Safety	High	The Health Board should develop a methodology / approach for establishing and undertaking an annual programme of workplace inspections. In particular, it should set out: how service areas / wards are selected for an inspection, including risk analysis, previous findings, incidents and Datix reporting; the approach to the inspection, including which health and safety areas are included. For example, there may be numerous priorities from one year to the next; methodology for undertaking the inspection, i.e. the process for completing one from start to finish; how assurance is provided to the sub-committees of the Board over how the programme of work is devised and that it is completed on schedule or otherwise; and findings from the workplace inspections are identified and acted upon.In addition, the Health Board should ensure that a programme of workplace inspections is developed and delivered in accordance with section 10.1 of the Occupational Health and Safety Policy. For example, the Health and Safety Committee may stipulate that all high risk areas are reviewed each year. Furthermore, if the programme is delivered late, then the Committee should receive assurances, together with an action plan for delivery to be returned to schedule.	An ABUHB health and safety monitoring manual will be developed. This will include a two year plan which outlines the audit/inspection delivery programme.The manual, including programme willbe presented at the ABUHB Health and Safety Committee in March 2018 for approval. The anticipated start date of the monitoring is 1stApril 2018.Future monitoring of the health and safety audit/inspection compliance will be presented via Divisional dashboards with an overview being presented at the ABUHB Healthand Safety Committee.	30/04/2018	N/A	N/A	Overdue	48	#VALUE!		November 2021 Update: the position has not changed since the last update in August 2021, however, a meeting is planned with colleagues in the Facilities Division this month to work collaboratively to develop a health and safety monitoring programme. The programme will include H&S management audits, thematic audits and 'walk the ward' inspections. The roll out of the new programme is planned for April 2022. In addition to this we are also planning the development of self-assessment inspection tools for wards and departments to be conducting their own health and safety monitoring. Finally, there is evidence that monitoring has been				07/05/2022	
	Internal	Health and Safety (2017/18)	Limited	Director of Therapies & Health Science	Head of Health and Safety	High	The Health Board should ensure that each area has completed an up-to-date health and safety risk assessment, by a trained co-ordinator. The risk assessment process should be overseen by the Health and Safety team, to ensure that it is completed in accordance with the Occupational Health and Safety Policy.In addition, the Health Board should review and refresh the list of safety co-ordinators and continue to do so following the initial update.The Health and Safety team should provide assurance and regular updates to the Health and Safety Committee over the status of risk assessments.	The monitoring of local risk management systems, including risk assessments will be included in the audit/inspection programme.The status of risk assessments will be reviewed and compliance reported via a dashboard to the ABUHB Health and Safety Committee and relevant Divisional forums.Further consideration is required to the utilisation of software to record and manage risk within the Health Board.	30/04/2018	N/A	N/A	Overdue	48	#VALUE!		August 2021: Due continued demands and impact from the pandemic within the Corporate Health and Safety Department the programme of health and safety monitoring has not re-started. However, monitoring has been conducted relating to COVID Safety				07/05/2022	
	Internal	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies & Health Science		High	R1 Registers should be maintained for operational management of medical devices and equipmenton each ward and department, which should record relevant equipment details.The register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed.Each areashould ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record itupon theirregister. Discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded. Going forward, relocation of equipment, disposals, additions etc. should be updated promptly to ensure an accurate record continues.	The Health Board to consider investing in an overarching equipment database register with staff resources to ensure regular updating and management.	31/03/2018	Nov-22	N/A	Deadline Revised	49	-7		Radio frequency ID tagging has commenced for all medical devices and will progress throughout 2022 . This will support the management and localtion of all devices including servicing history. Thetares are developing a register of all medical devices.				07/05/2022	
	Internal	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies & Health Science		High	R2 A clear robust control mechanism should be established by the divisions / directorates demonstrating the consideration and delivering of applicable training,aligned to medical equipment and devices. Training records should also be uploaded onto ESR.The poor mandatory training compliance rates with regard to infusion devices / pumps should be addressed as a matter of urgency.	From a Divisional perspective, the cascade training provided at ward level has not raised any particular safety issues, although with the increasing use of bank and agency staff, consideration should be given to accessible on site training for these members of staff. The Health Board to consider establishing a catalogue of equipment that needs specific training to operate, alongside a database of staff compliance.	31/03/2018	Jun-22	N/A	Deadline Revised	49	-2		An infision device training strategy was presented to the April Medical devices Committee. A training implementaion plan is now under development to support the roll out of a more resilient process in line with the strategy.				07/05/2022	
	Internal	Pay Incentives (2019/20)	Limited	Director of Operations		High	R1 The Health Board should restrict additional session payments to standard levels, but where this is not possible; maintain an approved schedule of enhanced rates ratified by the Executive Team with appropriate justification / reasoning included. The schedule of enhanced rates should be reviewed frequently e.g. every three months.	Approval to continue paying WLI rates from Executive Team – taken forward to RATS Committee. Review as part of IMTP demand and capacity discussions each year.	30/09/2019	N/A	N/A	Overdue	31	#VALUE!		November 2021 Update: Rate card has been revised and drafted across all divisions and will be shared and signed off by the Divisonal Director's with a view to sign of at Execs for the end of November, with the agreement of the MD				07/05/2022	
	Internal	Pay Incentives (2019/20)	Limited	Director of Operations		High	R2 In relation to the non-automated process only, consultants should submit signed claim forms for all additional sessions they are claiming payment for, listing appropriate details in respect of session dates, start/ finish times etc. and including a declaration that all sessions claimed are in addition to contracted work. The submitted claim form should be reviewed, validated and checked for accuracy before any payment is made.	Agreed. Executive Team will agree the approved system for claiming for all additional sessions and communicate with the Health Board. This must simplify the process for claiming to maximise compliance.	30/09/2019	N/A	N/A	Overdue	31	#VALUE!		April 2022 Temporary additional sessions for Consultants and SAs staff are agreed as part of the job planning process and paid at the doctors usual rate and annotated on the job plan proforma.				07/05/2022	
2021.16	Internal	Flu Immunisation	Reasonable	Director of Public Health and Strategic Partnerships	Consultatnt in Public Health	Medium	R1 a.The Health Board should review and investigate all promotional activity and flu vaccination delivery methods to determine the degree of success each brings. Alongsidethis, a reflection exercise should be completed to identify any lessons to be learnt or improvements to incorporate in future campaigns R1 b.Theflu champion database should be reviewed, updated and regularly maintained.	a.The Health Board will be holding annual Staff Flu Vaccine planning event for 2022-23 in April/May 2022. This report will be shared with the Staff Flu Working Group in advance to ensure that members have the opportunity to reflect on this report. This event will both reflect and act on the lessons learnt during the provision of staff vaccines during 2021/22,from an operational, communication and organisational view,as well as providing analysis of all available division/flu champion/vaccination data. Lessons learnt will be highlighted during this event and 2022/23 will be planned strategically to take advantage of positiveaspects, such as the mass vaccination centre approach (if an option), improving the flu champion model through improved digital innovation/organisational planning as well as mitigating barriers to vaccine uptake born of the staff survey/reflections.It is intended to be supported by a staff survey of "how they felt the vaccine programme did." It will form the basis of a user centred approach by listening to employee concerns as well as an opportunity to capture staff ideas.In addition,itis anticipated that greater use of technology will be implemented which will offer a	31/07/2022	N/A	N/A	Not yet due	-3	#VALUE!						07/05/2022	07/04/2022
2021.16	Internal	Flu Immunisation	Reasonable	Director of Public Health and Strategic Partnerships	Consultatnt in Public Health	Low	R2 a. The terms of reference for both Working Groups should be reviewed and updated where required. R2 b. The terms of reference for each group should be finalised.	a.Staff Flu Immunisation Working Group will review and update the Terms of Reference at the planning event b.Staff Flu Immunisation Working Group Terms of Reference will be finalised once reviewed.c.Community Flu Immunisation Working Group Terms of Reference will be reviewed and finalised.	31/07/2022	N/A	N/A	Not yet due	-3	#VALUE!						07/05/2022	07/04/2022
2021.15	Internal	Falls Management	Reasonable	Director of Therapies & Health Science		High	R1 a.Identify any underlying reason for the non-completion of MFRAsand the impact of the pandemic.	a.It is recognised that the non-completion of the falls risk assessment is multifactorial and the challenges have been heightened during the Covid pandemic. This is both in association with the changing levels of comorbidities for our patient cohort and the availability of staff resources due to competing demands in support of the Health Boards response to the pandemic.Some wards were also subject to changes in their functions with the redistribution of patients in support of the management of the pandemic. The Health Board through its falls management structure will continue to utilise both qualitative and quantitative information to identify themes and trends to instigate the necessary quality improvement initiatives. This will look to include a broader remit of evaluating compliancewith the completion of the MFRAthrough the development of an audit suite aligned to and extending the existing methods being adopted by the wards. The outcomes will look to define any change requirements and will be communicated at all levels within the organisationstructures.	31/07/2022	N/A	N/A	Not yet due	-3	#VALUE!						07/05/2022	07/04/2022
2021.15	Internal	Falls Management	Reasonable	Director of Therapies & Health Science	AD of Therapies & Health Sciences		R1 b.Review the MFRA documentation to determine if it can be rationalised / updated to be more concise. For example, a permanent section and an ongoing care plan that is periodically revised.	b.The MFRA represents one assessment within the suite of the Welsh National Care Records (WNCR). This is due to be adopted in its intended electronic format in ABUHB in the Summer of 2022and will provide a more streamlined systematic MFRA. Although currently being used in a paper format ABUHB as part of the process have submitted a number of change requests,which have been accepted. The detail held within the MFRA is reflective of the many factors which influence the risks of falls and likewise contribute to the wider understanding of the patient's condition. ABUHB is represented at National level and will continue to contribute to the discussions.	30/09/2022	N/A	N/A	Not yet due	-5	#VALUE!						07/05/2022	07/04/2022
2021.15	Internal	Falls Management	Reasonable	Director of Therapies & Health Science	AD of Therapies & Health Sciences		R1 c.Continue with the falls management training, but target the programme towards areas of poorer compliance rates.	c.It is recognised that training is a key component in supporting the ABUHB's approach in minimising inpatientfalls. The aim is to build on what has already been established. The evaluation of data willlook to underpin a focussed approach where areas of concern are identified and will look to inform the training strategy going forward. Aligned to the work of ABUHB we are also representedat an 'All Wales's levelin discussions to develop a generic learning platform linked to ESR to support all staff who have a role infalls management. It is intended that this will translate into a national product and provided consistency of approach across Wales.This platform will support enhancing knowledge and skills from both an inpatient and community perspective. The learning package will provide a level 1-2 education upon which additional modules will be developed.	31/12/2022	N/A	N/A	Not yet due	-8	#VALUE!						07/05/2022	07/04/2022
2021.15	Internal	Falls Management	Reasonable	Director of Therapies & Health Science	AD of Therapies & Health Sciences		R1 d. Remind staff of the falls management requirements.	d.Through the newly established structure in support of falls management an ongoing awareness campaign is to be established. The further development of theintranet pages through SharePoint willthe provideenhancedcommunication approaches. This will be looked at in the context of falls from a Hospital and Community perspective.This will be used to develop a falls network, provide a platform to share good practice, research and act as a resource depository.The concept of falls champions will be promoted. All will look to support quality improvement initiatives across the falls pathways. The agendas set for the fall'sforums will look to ensure suchgood practice, learning and necessary change initiatives continue to promote the requirements to manage falls.	30/09/2022	N/A	N/A	Not yet due	-5	#VALUE!						07/05/2022	07/04/2022
2021.15	Internal	Falls Management	Reasonable	Director of Therapies & Health Science	AD of Therapies & Health Sciences		R1 e.Where 1P1D/DECi inspections identify failures an immediate correction of the patient record and a rerun of the check (and potentially training) should be completed.	e.Should non-compliance concerns be identified the findings are shared with the Nurse in Charge, Ward Manager along with the Senior Nurse and QPS Lead. The outcomes are relayed to the member of staff responsible for the care of the patient and the wider team as a means of learning.The responsible member of staff looks to action any requirements to rectify non-compliance. The QPS Lead subsequently undertakes a more extensive focussed audit to identify any systemic concerns within the given ward and to inform the Divisional 'deep dive' discussions. Work is underway to look at how the data can be cross referenced with the overarching falls management data and on the reinstatement of the Health and Care Standards Audits. This approach will look to be supported by the training strategy.	31/12/2022	N/A	N/A	Not yet due	-8	#VALUE!						07/05/2022	07/04/2022
2021.15	Internal	Falls Management	Reasonable	Director of Therapies & Health Science	AD of Therapies & Health Sciences	Medium	R2. The falls investigation and Datix recording process should reference the MFRA and confirm its completion in relation to the fall event. A fall should not be identified as 'unexpected' if a MFRA had not been completed, when it should have been (e.g. over the age of 65 years).	An ongoing audit process will be established aligned to evaluating the completion of DATIX incidents and the associated completion of the MFRA and will be included as an element of an audit cycle Due consideration will need to be given to the format of the incident reporting criteria within the new system.	30/09/2022	N/A	N/A	Not yet due	-5	#VALUE!						07/05/2022	07/04/2022
2021.14	Internal	GUH: Quality Assurance	Reasonable	Director of Planning, Performance, Digital & IT		Medium	R1.1 Management should confirm available data and conclusions relating to functionality of the GUH, by comparison to business case objectives pre and post opening.	Agreed	TBC	N/A	N/A	Not yet due	#VALUE!	#VALUE!						07/05/2022	07/04/2022
2021.14	Internal	GUH: Quality Assurance	Reasonable	Director of Planning, Performance, Digital & IT		Medium	R1.2 Management should re-baseline relevant, objectives for the facility based on current information in order to inform revised functional	Agreed	TBC	N/A	N/A	Not yet due	#VALUE!	#VALUE!						07/05/2022	07/04/2022
2021.14	Internal	GUH: Quality Assurance	Reasonable	Director of Planning, Performance, Digital & IT		Medium	R2.1 Management should confirm an appropriate forum to which to report on-going monitoring of the investment benefits derived from the GUH facility.	Agreed. The reporting of the energy efficiency benefits of GUH will be picked up as part of the broader energy review and discussed at the Strategic Capital & Estates Group.	TBC	N/A	N/A	Not yet due	#VALUE!	#VALUE!						07/05/2022	07/04/2022
2021.12	Internal	Risk Management	Reasonable	Board Secretary	Head of Risk	Medium	R1.1 The Health Board should: • Develop a plan setting out how key objectives within the Risk Strategy will be achieved, with milestones set out. The progress of the plan should be reported into the Audit, Finance and Risk Committee. • Review the Risk Strategy to determine if it still reflects current practice and update it accordingly e.g. the corporate overview or risks.	A plan has been developed and is being presented to the Audit Committee on 7th April 2022 following discussion with Executive Team. A review of the Strategy will be undertaken as part of the plan, in September 2022, specifically to review effectiveness one year post implementation.	30/09/2022	N/A	N/A	Complete	-5	#VALUE!		Risk Strategy Realisation Plan agreed. Routine updates scheduled within ARA Committee workplan for 2022/23				07/05/2022	07/04/2022
2021.12	Internal	Risk Management	Reasonable	Board Secretary	Head of Risk	Medium	R2.1 The Health Board should: • Consider undertaking risk management training for key areas, whilst awaiting the implementation of the risk management module within DatixCloudIQ. • Develop a plan to deploy risk management training, to commence once the full implementation of DatixCloudIQ has been completed.	As part of the strategy realisation plan, the Health Board will develop an in-house training package aimed at the three levels outlined within the Strategy (operational, management and Board level). This will be made available to relevant staff during May/June 2022. Further National development work will resume once the RLDatix risk management module has been finalised and bespoke training programmes can then be developed.	30/06/2022	N/A	N/A	Not yet due	-2	#VALUE!						07/05/2022	07/04/2022
2021.12	Internal	Risk Management	Reasonable	Board Secretary	Head of Risk	Medium	R3.1 The Health Board should: • Provide guidance detailing how risks should be recorded and monitored at different levels within the organisation. • Ensure each risk entry is fully recorded in a standard format.	3.1 This recommendation forms part of the Risk Management Strategy realisation plan. The Health Board training programme will provide material and literature to help support staff to populate Datix and risk registers appropriately and consistently ensuring alignment with best practice. The provision of in-house training will be made available to staff by May/June 2022.	30/06/2022	N/A	N/A	Not yet due	-2	#VALUE!						07/05/2022	07/04/2022
2021.13	Internal	Continuing Healthcare MH&LD	Limited	Director of Primary, Community Care and Mental Health	Divisional Nurse/Divisional Director	High	R 1.1 The Division should further strengthen performance reporting, with a heightened focus on QPS metrics (akin to the processes embedded with the Complex Care Division: general adults). 1.2 The Division should explore interim options to automate and streamline the existing databases until the introduction of WCCIS, and ensure the databases are up to date. 1.3 The Division should improve the reporting arrangements of commissioned services ensuring Executive sightedness together with Patient Quality, Safety & Outcomes Committee. 1.4 The Divisional Risk Register should be updated to include the risk associated with the	1.1 The Performance report will be strengthened to include PQS metrics. 1.2 The utilisation of the databases will be reviewed with an interim plan developed to reduce duplication and ensure completeness. 1.3 A quarterly performance report will be produced and discussed at Divisional level and the Executive Assurance meeting, together with inclusion in the PQSOC Performance Report as per the business cycle.1.4 The Divisional Risk register will be updated to include the risks associated with the auditing backlog.	30/06/2022	N/A	N/A	Not yet due	-2	#VALUE!						07/05/2022	07/04/2022
2021.13	Internal	Continuing Healthcare MH&LD	Limited	Director of Nursing/Director of PCCMH		High	3.1 a. The Health Board should explore options for strengthening its oversight of services commissioned, on its behalf, through the NCCU, with reporting to the PQSOC. b. The Health Board should request the NCCU informs commissioners when providers do not re-join the AWF.	a. This Audit recommendation will be discussed with the NCCU to explore opportunities for strengthening monitoring and ABUHB oversight. b. The NCCU will be asked to inform ABUHB when a provider does not re-join the AWP list.	30/04/2022	N/A	N/A	Complete	0	#VALUE!						07/05/2022	07/04/2022
2021.13	Internal	Continuing Healthcare MH&LD	Limited	Director of Primary, Community Care and Mental Health	Divisional Nurse/Divisional Director	High	4.1 Divisional management should ensure: a. the Division introduces a sustainable programme of training for CHC; and b. CHC compliance and quality audits are incorporated into the Divisional clinical audit plan.	a. A business plan inclusive of the training requirements for Commissioning is being considered by the Divisional Management Team in conjunction with other IMTP priorities. The CHC framework forms part of the training needs identified. A bid for temporary funding for training personnel will be prepared to address this issue quickly. b. Clinical auditing of the CHC process will be added to the annual Divisional audit plan.	30/06/2022	N/A	N/A	Not yet due	-2	#VALUE!						07/05/2022	07/04/2022
2021.13	Internal	Continuing Healthcare MH&LD	Limited	Director of Primary, Community Care and Mental Health	Divisional Nurse	High	R5.1 A revised framework, following the launch of the new national CHC policy (anticipated April 2022), should include client-specific requirements for MH & LD and ensure consistent use across all Health Board services.	5.1 The Deputy Divisional Nurse for MH/LD will work closely with the Divisional Nurse for Complex Care to ensure inclusion of MH/LD client specific requirements within the revised framework for CHC, following the launch of the new national policy.	30/06/2022	N/A	N/A	Not yet due	-2	#VALUE!						07/05/2022	07/04/2022
2021.13	Internal	Continuing Healthcare MH&LD	Limited	Director of Primary, Community Care and Mental Health	Divisional Nurse	Medium	R2.1 Clarity should be provided in terms of the roles and responsibilities of the Commissioning Team and the Care Coordinators, particularly associated with annual reviews.	2.1 The respective roles and responsibilities of the Commissioning Team members and Care Coordinators will be reinforced, ensuring clarity.	31/03/2022	N/A	N/A	Overdue	1	#VALUE!						07/05/2022	07/04/2022
2021.13	Internal	Continuing Healthcare MH&LD	Limited	Director of Primary, Community Care and Mental Health	Divisional Nurse/Finance Business Partner	Medium	R6.1 The Division should: a. undertake a review of its overarching CHC / S117 provider contracts, ensuring they include all aspects of performance monitoring; b. identify appropriate signatories for the contracts in line with the Standing Orders and Scheme of Delegation.	6.1 a. A Task and Finish Group will be convened to review and strengthen the contracts. b. The authorised signatories list will be reviewed to ensure full compliance with the Scheme of Delegation and Standing Orders.	31/07/2022	N/A	N/A	Not yet due	-3	#VALUE!						07/05/2022	07/04/2022
2021.17	Internal	Corporate Governance: BAF	Reasonable	Board Secretary	Head of Risk	Medium	We recommend that the Health Board assesses the effectiveness of those assurances on which reliance is being placed, and report their findings or gaps identifiedas part of the BAF reporting structure.Where gaps are identified action plans should be developed and monitoredfor progress.	R1. The Health Board accepts this recommendation as part of the iterative development of the Board Assurance Framework. Work to address this recommendation is planned during May/June 2022 and a revised BAF incorporating a robust assessment of assurances will be included. Assurances will be RAG rated and identified gaps will have associated plans to improve the position, monitored by the Audit,Risk and Assurance Committee.	31/07/2022	N/A	N/A	Not yet due	-3	#VALUE!						07/05/2022	30/06/2022
2021.17	Internal	Corporate Governance: BAF	Reasonable	Board Secretary	Head of Risk	Medium	R4. We recommend that the Health Boarddevelops a periodic report commenting on compliance/ the effectiveness of the BAFprocessand reports this to an appropriate committee.	The Health Board accepts this recommendation and will incorporate a review of the effectiveness of the BAF into Board evaluation and committee self assessment processes.	30/04/2023	N/A	N/A	Not yet due	-12	#VALUE!						07/05/2022	30/06/2022
2021.17	Internal	Corporate Governance: BAF	Reasonable	Board Secretary	Head of Risk	Low	R2. We recommend that the Health Board completes an assurance mapping exercise to record all assurances being sought in relation to those principalrisks reported under the BAF process. The exercise should be regularly reviewed to identify any missing and / or the accuracy of theassurance.	The Health Board accepts this recommendation and actions to undertake this are outlined in recommendation 1. The Health Board has established processes in place to review the BAF at least twice yearly with all principal risks reported to executive team, relevant committees and to the Board at each meeting.	31/07/2022	N/A	N/A	Not yet due	-3	#VALUE!						07/05/2022	30/06/2022
2021.17	Internal	Corporate Governance: BAF	Reasonable	Board Secretary	Head of Risk	Low	R3. We recommend that the Health Board continues to monitor the embedding of the BAF related risk management oversight responsibilities of the Committees to ensure that:1 the Committee Risk papers form the basis of the six monthly BAF reporting to the Audit, Risk and Assurance Committee and the Board; and,2 appropriate oversight is provided by each Committee on reported BAF activity.	The Health Board accepts this recommendation and plans to include strengthened assurance mapping arrangements and assessments for the next iteration of the Board Assurance Framework (BAF). In addition to this, the template reporting for Board and Committees is due to be reviewed, it is proposed that incorporated into this review will be the ability to cross reference each Board and Committee report to the BAF to make explicitly clear where papers address and provide assurance against a principal risk.	31/07/2022	N/A	N/A	Not yet due	-3	#VALUE!						07/05/2022	30/06/2022
2021.18	Internal	Financial Sustainability	Reasonable	Director of Finance, Procurement & Value	Assistant Finance Director	Low	R1 The upcoming review of theBudgetary Control Policy and Financial Control Procedure, issue 3, should considerestablishing effective control procedures that allow for practical compliance across the Health Board and that any accepted deviation from defined procedures isdocumented, such that authorisation of such changes is defined and communicated. Areas for consideration include:1.1.1whetherthe formal budget delegation and acceptance letter process applied to the initial annual budget needsto be applied to any significantbudget changes madeduringthe financial year;1.1.2shouldthe monthly budget review and reporting processes reflect the specific needs of each division / directorate, given an assessment of the variation in budget risk between the divisions; and1.1.3whethereach virement requiresformal approval by the Board or could delegation of authority be given to the ExecutiveTeamwith the subsequent notification to the Board, subject toappropriatefinancial limits.The full findings of this review should be consideredwhen the documents are reviewed.	1.1.1Delegation of such large £'s during the year is relatively recent and became apparent during Covid due to late notice of confirmation and receipt of funding.We would normally expect to issue delegation letters only at the start of the financial year, whenthe vast majority of budgets are delegated, recognising that these are at a point in time, there will always be subsequent changes as new funding is agreed.The delegation is approved by the CEO and the expectations of managing that budget are clear in the initial letter and FCP's. The FCP will be reviewed and revised to reflect the clarity of this process. 1.1.2The Board financial report includes an overview of each budget head.'FBI' provides the standard ABUHB Budget holder reports in detail.No action proposed. 1.1.3The budget is delegated through the Board and CEO to the Executive, to deliver the agreed priorities. There should be no need to refer changes to the Board as they have already delegated the authority of its management. However, where there are significant changes to the proposed usage which are outside of agreed priorities and delegation arrangements, there is an expectation that the Board	31/08/2022	N/A	N/A	Not yet due	-4	#VALUE!						07/05/2022	30/06/2022
2021.18	Internal	Financial Sustainability	Reasonable	Director of Finance, Procurement & Value	Assistant Finance Director	Low	R2 The Directorof Finance, Procurement& Valueshouldensurethatthe budgetarycontroltraining provided is appropriate and that each staff member receives an adequate level oftraining toaddress their needs andfulfil their role.This should includetheinclusion of budgetary control training in staff PADRs (where appropriate),monitoring attendance at budgetary control training sessions,and clear, documented justification where a budget holder does not need to attend the training(for example, if they had significant budgetary control experience in a previous role).	Financial and budget training is part of induction training sessions and FBI training is provided in addition to encouraging budget holders to attend.Non attendance reports are provided to line managers and Business Partner Accountants teams to follow up.Reminders will be sent to all budget holders and line managers to ensure attendance	31/08/2022	N/A	N/A	Not yet due	-4	#VALUE!						07/05/2022	30/06/2022
2021.18	Internal	Financial Sustainability	Reasonable	Director of Finance, Procurement & Value	Assistant Finance Director	Low	R3.1 Going forward, the Director of Finance,Procurement& Valueshouldconsider enhancing/ expandingthe Board reporting around the delivery ofsavings plans, as pressure to deliver a sustainable balanced budget becomesever increasing.	Savings information is provided in summary in the Board Financial Report, in addition the appendix provides a line by line analysis.The Finance & Performance Committee will receive a more detailed savings analysis as part of regular agenda updates, including analysis of recurrent, non-recurrent and delivery performance.	31/07/2022	N/A	N/A	Not yet due	-3	#VALUE!						07/05/2022	30/06/2022
2021.18	Internal	Financial Sustainability	Reasonable	Director of Finance, Procurement & Value	Assistant Finance Director	Low	R3.2 Whilst savings are not separately budgeted for, the Director of Finance, Procurement & Values should consider the reporting of savings achieved analysed by key generic savings activities across the Health Board. For example,an analysis of savings planned and achieved fromthe more effective management of variable paycosts across the Health Board, orthe avoidance of additional costsas a result of efficiencies achieved.	Savings information is provided in summary in the Board Financial Report, in addition the appendix provides a line by line analysis.The Finance & Performance Committee will receive a more detailed savings analysis as part of regular agenda updates, including analysis of recurrent, non-recurrent and delivery performance.	31/07/2022	N/A	N/A	Not yet due	-3	#VALUE!						07/05/2022	30/06/2022
2021.18	Internal	Financial Sustainability	Reasonable	Director of Finance, Procurement & Value	Assistant Finance Director	Medium	R4.1 The Health Board should ensure clear alignment between itsTransformation Projects, IMTP Core Priorities and Priority Programmes.	Agreed.Implemented as part of IMTP 22/23 –24/25	30/04/2022	N/A	N/A	Complete	0	#VALUE!						07/05/2022	30/06/2022
2021.18	Internal	Financial Sustainability	Reasonable	Director of Finance, Procurement & Value	Clinical Futures Programme Director	Medium	R4.2 Before Transformation Projects are put forward for review and approval, the Health Board should ensurethat SMART criteria for measuring a project's development and "what success looks like" aredefined, and theaccounting structures to be applied to record each project are documented and subject to review.	Agreed. Each Programme should have benefits criteria agreed by its own Programme Governance and signed off by the Clinical Futures Programme Board (HSLG). The SRO should lead the development of the benefits measures with support from business partners and programme leads Finance Leads to be allocated to IMTP priorities programmes. Accounting of efficiency and savings progress to be captured in financial management information packs.	31/07/2022	N/A	N/A	Not yet due	-3	#VALUE!						07/05/2022	30/06/2022
2021.18	Internal	Financial Sustainability	Reasonable	Director of Finance, Procurement & Value	Assistant Finance Director	Low	R4.3 The Health Board should ensure that Transformation Projects areexpressed as financially sustainable with identified funding from redeployment of existing budgets and/or non-recurrent funding sources.	Agreed in principle. Recommendations from programme workstreams will be considered through organisation planning, reporting andgovernance arrangements ultimately to Executive Team and the Board.	30/06/2022	N/A	N/A	Not yet due	-2	#VALUE!						07/05/2022	30/06/2022
2021.18	Internal	Financial Sustainability	Reasonable	Director of Finance, Procurement & Value	Assistant Finance Director	Low	R4.4 There is an inherent risk that elements of non-recurrent funding of Transformation Projects are not forthcoming in future years. Any decision to continue projects without an identified recurring source of income risks financial sustainability in future years.Therefore, the Health Board should consider developing a clear mechanism to compare projects to allow for clear decision making where funding resources are limitedandthere may be a need to prioritise Transformation Projects.	Agreed. Aprioritisation process to support resource allocation as part of IMTP development is being developed by the Executive team for consideration by the Board.	30/06/2022	N/A	N/A	Not yet due	-2	#VALUE!						07/05/2022	30/06/2022
2021.20	Internal	Medicines Management	Reasonable	Medical Director	Senior Primary Care Pharmacist	Low	R1 Management should review the terms of reference (ToR) for theGwent Controlled Drugs Local Intelligence Network,including its quoracyrequirements. Meetingsthatare not quorate should either be deferred or recognised at the start of the meeting ensuring those in the meeting understand the implications of this.The requirement to complete minutes and action logs after each meeting should also be added to the ToR.	The terms of reference of the Gwent CDLIN will be reviewed and updated as requested at the next CDLIN on 1stAugust 2022.1.The TOR will be updated to remove need for Police representation at each member.2.To recognise any non-compliance with quoracy requirements at the start of any meeting. The implications of this to be noted in the minutes. 3.To add the requirement to complete minutes and action logs after each meeting will be added to the TOR.	31/08/2022	N/A	N/A	Not yet due	-4	#VALUE!						07/05/2022	30/06/2022
2021.20	Internal	Medicines Management	Reasonable	Medical Director	Head of Pharmacy - Operational Services/Principal Technician, Pharmacy Technical Services	Medium	R2.1 Management should review the Policy for the Management of Controlled Drugs and update where required.	The CD Policy is due for review during 2022/23. As in previous reviews a working group with representatives from Pharmacy and nursing will be set up to update the policy. A number of sections and standard operating procedures will be updated to make the policy more relevant and practical. This will support compliance with the policy. Controlled drug keys being held on their own may have been best practice. However, this may not be convenient on the wards. This could be removed in the updated version.The use of red pen on the wards is to make stock checks morevisible. The practicality of this will be reviewed.Keeping patients own CDs on a separate shelf may not always be possible. However, they should be clearly differentiated from ward stock.The policy will also include a description of the audit framework that will provide assurance the policy is being followed.	31/03/2023	N/A	N/A	Not yet due	-11	#VALUE!						07/05/2022	30/06/2022
2021.20	Internal	Medicines Management	Reasonable	Medical Director	Head of Pharmacy - Operational Services/Principal Technician, Pharmacy Technical Services	Medium	R2.2 Once the Policy for the Management of Controlled Drugs is updated, the Health Board should undertake periodic reviews to ensure wards are adhering to the updated Policyand confirm the areas of non-compliance identified as part of this review have been rectified.	The stand operating procedure for pharmacy 6 month stock check on the wards is being updated by a Principal Pharmacy Technician. This will include updating the way reconciliation checks confirmation are documented to ensure compliance.The policy can include the need for periodic audits to review use of the policy and confirm areas of non compliance have been rectified.	31/03/2023	N/A	N/A	Not yet due	-11	#VALUE!						07/05/2022	30/06/2022
2021.20	Internal	Medicines Management	Reasonable	Medical Director	Head of Pharmacy - Operational Services/Principal Technician, Pharmacy Technical Services	Medium	R3. Management should continue as planned to add the Omnicell user guides to Sharepoint and direct staff to this learning material. The guides should be useful to the front end user and also to Ward Managers regarding the reporting capabilities within anOmnicellmachine.	There are user guides for both end and superusers provided by Omnicell. The Principal Pharmacy technician at RGH has developed basic user guides for the wards which detail the common functions with picture guides. These are available on the wards, but staff cannot always find them. The plan is to add them to SharePoint and signpost staff to them. Short training videos are also to be developed which will be uploaded toYouTube. QR codes will be placed on the side or front of the cabinet and linked to the videos which will show staff how to maximise the Omnicells functionalities.	31/08/2022	N/A	N/A	Not yet due	-4	#VALUE!						07/05/2022	30/06/2022
2021.20	Internal	Medicines Management	Reasonable	Medical Director	Head of Pharmacy - Operational Services	Medium	R4 The PharmacyTeamshould comply with the relevant Health Board policies and SOPs for controlled drugs, in particular the removal of expired controlled drugs and the completion of six-monthlystock reconciliations(which should all be completed in a consistent manner). Where compliance with the policycannot be achieved, for example due to resourcing, an agreed temporary deviation from the Policy should be agreed and approved at anappropriateGroup.	A full review will be conducted into the Pharmacy processes relating to 6-monthly CD stock reconciliations to determine the extent of the issue and to provide assurance of compliance. The Pharmacy Team will input into the Management of Controlled Drugs Policy, with the potential to visit the mechanism of how expired drugs are reported to Pharmacy, to ensure a more robust system with auditable records is available in the future.	30/09/2022	N/A	N/A	Not yet due	-5	#VALUE!						07/05/2022	30/06/2022
2021.22	Internal	NIS Directive (Cyber Security)	Reasonable	Director of Planning, Performance, Digital & IT	Chief Digital Officer	Low	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	N/A	N/A	Not yet due	-8	#VALUE!						07/05/2022	30/06/2022
2021.22	Internal	NIS Directive (Cyber Security)	Reasonable	Director of Planning, Performance, Digital & IT	Chief Digital Officer	Medium	R2 Management should ensure that records of discussions and information provided to and from the CRU are captured for future annual self-assessments.	Management will ensure that during any future self-assessments records of discussions and informationsupplied to the CRU will be captured and available for internal or external review.	31/12/2022	N/A	N/A	Not yet due	-8	#VALUE!						07/05/2022	30/06/2022
2021.22	Internal	NIS Directive (Cyber Security)	Reasonable	Director of Planning, Performance, Digital & IT	Chief Digital Officer	Medium	R3 Management should ensure that an Improvement Action Plan is developed promptly in order to avoid delays in implementation.	NIS Improvement Plan is already being developed by the Cyber Team. Thecompleted plan willbe presented for management review and sign off. Currently ABUHB are still awaiting the publication ofCAF Based Cyber Risk Register for the Health Board these risks identified by CRU following the CAF assessment may include remediations that will be incorporated into the Improvement Plan currently being	31/07/2022	N/A	N/A	Not yet due	-3	#VALUE!						07/05/2022	30/06/2022
2021.22	Internal	NIS Directive (Cyber Security)	Reasonable	Director of Planning, Performance, Digital & IT		Medium	R4 The costs associated with the improvement actions should be assessed and reported to a relevant committee to enable awareness of the full picture and prioritisation of actions and funding.	The NIS Improvement Plan will be submitted through the relevant governance committee for senior Management review and sign off. Prioritisation of remedial actions and related costs will be assessed through ABUHB formal risk governance structureand relevant committees. Note ABUHB are currently implementing the	30/09/2022	N/A	N/A	Not yet due	-5	#VALUE!						07/05/2022	30/06/2022

ABUHB	Audit	Report Title	Assurance	Director	Responsible	Ref /	Recommendation	Management Response	Agreed	Revised	Revised	Due	No. of	No. of months	If closed	Progress being made to implement recommendation				Reporting Date	Date Added to
	Internal	IT Service Management, May 2018	Limited	Director of Planning, Digital & IT	Associate Director of Informatics	High	R3 Informatics should seek to develop a SKMS in order to share knowledge across departments. This process should include developing a Knowledge Centred Service (KCS) process within the service desks and ensuring models for calls and problems are catalogued and indexed and easily available.	AcceptedWe recognise that this is a priority and that Service Point does not meet the needs of the service to develop the KCS (also identified by this audit) and therefore, Informatics will undertake a scoping and options appraisal exercise to define the requirements, including the resource needed.A business case has been developed for ICT only that seeks to address the concernswithin ICT; this work will inform the requirements of a similar review for Informatics.	31/10/2018	Feb-22	Jan-19	Overdue	42	3		**May 2022** update: A comprehensive SKMS has now been implemented comprising a knowledge base with c. 1000 articles, a fully indexed and searchable shared document repository and a service catalogue of all Informatics services, fully described for our key services. All areas are cross linked based on Service. Propose that this item can be closed November 2021 Update: Existing knowledge artefacts have been migrated to share point online and are fully searchable			Implement revised information architecture Define and Implement governance around permissions, review timescales and formats for new artefacts Establish links to service catalogue Ensure criteria for SDI Audit are met	07/05/2022	
	Internal	Clinical Futures - Transport, March 2021	Reasonable	Interim Director of Operations	Service Improvement Manager/ Service Lead / General Manager	Medium	R1 The Health Board should periodically review feedback from WAST / staff and patients, incidents, ongoing and expected future costs, overall performance and volume of patients etc. to ensure the expected benefits versus costs are still being achieved.	Agreed.The cost benefit analysis was reviewedagainst the original model and flagged as part of the Clinical Futures Readiness Assessment on 23rdJune. There will be ongoing monitoring of key KPIs.	31/12/2021	N/A	N/A	Overdue	4	#VALUE!						07/05/2022	
	Internal	Clinical Futures - Transport, March 2021	Reasonable	Interim Director of Operations	Service Improvement Manager	Medium	R2 The Flow Centre Team should:•review the current completion of the screening / transfer process documentation and establish a standard expectation of completeness;•provide refresher training to the team members, if required;•undertake periodic checks of all staff members, to ensure consistency and feedback any positive performances and improvements to individuals. This should also link into the PADR process;remind staff that the WAST incident number should be recorded to provide traceability; and•all screening questions shouldbe uploaded to CWS, where required.	Agreed. We will do this by:•implementing a staff review process, including an audit of referral information (this aspect is already implemented);•monitoringstaff performancee.g. logging in times and periodically listening to callsand to feedback onperformance;•addressing any training needs that ariseand link this to one-to-ones and the PADR process;•continuingto emphasise the importance of accurately recordinginformation e.g. WAST incident numbers, GP surgery etc.;•providingregular refresher training;and•hosting team meetings to share case studies / best practiceand address any issues / concerns that arise.	30/09/2021	N/A	N/A	Overdue	7	#VALUE!						07/05/2022	
	Internal	Clinical Futures - Transport, March 2021	Reasonable	Interim Director of Operations	Service Improvement Manager	Low	R3 We recommend that the Flow Centre Team produce and monitor regular performance information over key risks within the process. For example, call waiting times.As this process is already underway, the Team should continue to identify other key performance indicators.This information should also link into individual performance within the Team, for training and improvement.	Agreed. We will:•clarify the audience and reporting requirements;•monitor performance information / KPIs on a regular basis;•identify the top five indicators;•develop a reporting dashboard;and•further refine performance reporting.	30/09/2021	N/A	N/A	Overdue	7	#VALUE!						07/05/2022	
	Internal	Clinical Futures - Transport, March 2021	Reasonable	Interim Director of Operations	Service Improvement Manager	Low	R4 We recommend the Flow Centre Team undertake periodic test runs of the business continuity plan against different continuity events. Any learnings or improvements should be detailed specifically in the plan.	Agreed. We will finalise the business continuity plan(BCP)and undertake a test run, including a relocation planto the Grange University Hospital, if required. Any learning or improvements will be incorporated into the BCP.	31/12/2021	N/A	N/A	Overdue	4	#VALUE!						07/05/2022	
	Internal	Mental Health & Learning Disabilities Divisional Review, June 2021	Reasonable	Director of Primary, Community Care and Mental Health	SISU - Strategic Capital and Estates Programme Director and WPWS Programme Manager	Low	R3 We recommend that the Health Board ensure that for each of the MHLD projects that benefit realisation planning is extended to cover:•the collection of baseline data;•targets or success measures with which to compare what is actually achieved;•the measurement and recording of the benefit metrics;•responsible managers; and•the oversight body of the benefits, to ensure these are achieved.	Agreed. We acknowledge that a robust benefits realisation plan needs to be developed and we are looking to commission external support to assist with this process for the SISU Programme. A tender is currently developing a tender to progress this element of the project. This is part of the OBC development and will be completed before submitted to the Board for approval.WPWS –to review benefits realisation plans for supporting projects	30/09/2021	N/A	N/A	Overdue	7	#VALUE!		April 2022 Update: There has been a delay to gaining external support for the benefits realisation plan due to Omicron variant service impact. However Internal benefits work has been undertaken and measurable benefits developed for each service area within SISU. The OBC including benefits realisation is planned to be completed and submitted to the September Board. Benefits realisation plans and measures are being built in to all workstreams of WPWS work. Sanctuary project is				07/05/2022	
	Internal	Staff Experience June 2021 *(Advisory Report)*	Not Rated	Director of Workforce & OD		N/A	R3 RecommendationThe Health Board should:•Review each initiative versus the time and financial cost to provide the service against the staff uptake and value / benefit of the initiative. •Consider additional analysis to help assess and target wellbeing initiatives to staff requirements.•Consider establishing wellbeing KPIs or other performance metrics to measure the success of the strategy and specific initiatives.	Calculating the relationship between financial investment and value is a complex process due to the range of clinical and individual variables. Outcome data is regularly collected and evidence based practice followed, the evidence base is evolving and ABUHB is at the forefront of developing this evidence and outcome data.The additional analysis recommended will be provided via the quarterly well-being surveys and deep dive work within divisions. The next well-being survey has enhanced questions that link back to the 6 pillars of the Employee Experience Framework.•The Employee Well-being team will take the recommendation around KPI'sunder consideration and further explore the additional functionality of the new version of the clinical recording system(CORE)now in use.	31/03/2022	N/A	N/A	Overdue	1	#VALUE!		**April 2022** The wellbeing needs of the workforce are complex and evolving, our methods of monitoring offer valuabel high level insight but limited granularity. We stematically evaluate all clincial interventions, as well as new service delivery models (e.g.: psychological trauma pathway) to dettermine effectiveness and monitor safety. Our new CORE based data base has offered us increased opportunity to monitor				07/05/2022	
2021.04	Internal	Charitable Funds	Substantial	Director of Finance	Charitable Funds Manager	Medium	R1 The Health Board should:a)Engage with ward staff via alternative mediums, e.g.,Teams presentations, presentations to Divisional Management Team meetings.b)Establish a timeframe for restarting ward visits and training sessions.c)Continue to promote the Charitable Funds Financial Control Procedure.	a.Agreed. Presentations to be prepared by December 2021 with roll out to commence in the new year with a view to completing by March 2022, confirming suitable dates with the divisions. b.Agreed. Face to face meetings will be dependent on advice from Infection Prevention and Controlbut meetings will be arranged by Teams liaising with relevant ward staff to arrange meetings prior to March 2022.c.Agreed. There will be follow up e-mails by the Charitable Funds Team to a and b above providingthis information	31/03/2022	N/A	N/A	Overdue	1	#VALUE!						07/05/2022	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R2 The Health Board should seek clarity over why the requests made to DHCW and the SMBfor an integrated electronic process cannot be delivered.The Health Boardshouldcarryout an analysis to fully identifyits needsfor a Radiology system and seek to include these within WRIS or any future system.	We have tried to seek clarity and not had a full response.Arequest for CWS to include WCP for radiology reporting in the platformhas been formally raised. We haveraised the need for end to end requesting as a health board to the collaborativeboard for RISP project.	31/03/2022	N/A	N/A	Overdue	1	#VALUE!						07/05/2022	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R4 The Health Board should seek clarity over what maintenance tasksare expected and establish a process to ensure that these are completed.	There is a backupregimen in place, and DHCW has been notified of how this works.The point will be raised and the next WRIS SMB, and a request made for clarity over the expected database maintenance tasks and the frequency of these.	31/03/2022	N/A	N/A	Overdue	1	#VALUE!						07/05/2022	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R5 a.The Board should investigate an electronic solution to uploading requestsinto WRIS.b.The Board should introduce a completeness check to ensure that all requestsreceived have been entered into WRIS.	a.Radiology have requested CWS to work with WCP for fully electronic requesting. b.Staff have SOP's and checks when putting forms on however human errors do occur without fully electronic requesting.	31/03/2022	N/A	N/A	Overdue	1	#VALUE!						07/05/2022	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R8 The Health Boardshould request that this logging function be developed.The Health Board shouldconsider feeding WRIS events into the SIEM.	The health board have raised this at DHCW CAB along with other health boards. This is with DHCW to develop it is not in any Live RadIS version	31/03/2022	N/A	N/A	Overdue	1	#VALUE!						07/05/2022	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations		Low	R1 The Pathology Team should consider updating the External inspection Policy to include one centralised repository for all external reportsthat incorporatetimescales for a responseand provides a clear overviewof progressacross all areas.	Will ensure reportsare maintained in a centralised repositoryand ensure the policy is updated accordingly	24/02/2022	N/A	N/A	Overdue	2	#VALUE!						07/05/2022	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Pathology Governance Manager	Low	R2 a.All instances of non-conformance identified in the reports should be recorded centrally to support periodic trend analysisand in particular theCAPA module within QPulse.	a.Log UKAS inspection as one single CAPA within QPulse and update progress as per any other non-conformity	24/02/2022	N/A	N/A	Overdue	2	#VALUE!						07/05/2022	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Pathology Governance Manager	Low	R3 Liaise with the ABUHB emergency planning team to go through their process for completion of all business continuity	Discipline Managers have been liaising with emergency planning team and will continue to do so.	24/02/2022	N/A	N/A	Overdue	2	#VALUE!						07/05/2022	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Pathology Governance Manager	Medium	R4 Establish aschedule for testing BCPsat all locationsand across a range of likely continuity events	Will establish a schedule for testing across Pathology	24/12/2021	N/A	N/A	Overdue	4	#VALUE!						07/05/2022	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Pathology Governance Manager	Low	R5 The Pathology Team should seek to automate as much of the performance reporting as possibleand includeall test results within the	Will horizon scan for new technologies to deliver automated TATs	24/02/2022	N/A	N/A	Overdue	2	#VALUE!						07/05/2022	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Pathology Governance Manager	Medium	R6 If sampling cannot be avoided, the policy and process for sampling and reporting should be updated to include time limits for use and the requirement to confirm that the samplesizeis appropriate.	If sampling cannot be avoided, the policy and process for sampling and reporting should be updated to include time limits for use and the requirement to confirm that the samplesizeis	24/12/2021	N/A	N/A	Overdue	4	#VALUE!						07/05/2022	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Pathology Governance Manager	Medium	R7 A scorecard/ dashboard reportshould be developedto provide an overview of performance against the key measures/ risks	Scorecard currently in progress and being populated	24/12/2021	N/A	N/A	Overdue	4	#VALUE!						07/05/2022	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Assistant Directorate Manager	Low	R8 The Health Board should complete a refresh of the latest workforce planning exercise(including associated laboratory space and equipment), to ensure the service requirements can still be met over the next five years and beyond.Where additional resourcing / facilities arerequired, theseshould be factored into the IMTP process	To review and updateworkforce plans as appropriate. Workforce is factored into the IMTP	24/02/2021	N/A	N/A	Overdue	14	#VALUE!						07/05/2022	25/03/2022
2021.10	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates	High	R5 Confirmation notice 1 should be finalised as soon as possible for both the Cost Adviser and Project	Agreed. Both recommendations are being addressed as a matter of urgency.	30/11/2021	N/A	N/A	Overdue	5	#VALUE!						07/05/2022	25/03/2022
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R1 The governance framework for IM&T / digital should be clarified and where control over aspects of IM&T has devolved to departments, there should be a process for these to feed into the relevant Committee to ensure oversight. Underneath the Committee the steering group remit and membership should be defined.	Agreed. The Health Board is establishing a new governance framework. Currently Informatics is reporting to the Audit Committee, the first report is scheduled for 8thApril. A Health Board governance framework is in development for informatics including exec oversight, investment and delivery. The management of the global pandemic has disrupted the planning work by 12 months but this is now re initiated. Recommendations arescheduled to be presented to Exec TeamQ1 , and Board in Q2;	30/06/2021	N/A	N/A	Overdue	10	#VALUE!		November 2021 Update: Digital Delivery Board is now in place and divisional representation required. It will form part of the formal governance process. Updates will be provided from this Board to Exec Team.				07/05/2022	25/03/2022
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R2 A register of compliance requirements for all IM&T related legislation and standards across the whole organisation should be developed for the IGC along with a process for assessing status and reporting upwards to Committee.	Agreed. Currently the establishment, processes and mandate of informatics in ABUHB does not extend (with the exception of IG) beyond the directorate. In terms of accountability where devolved responsibility exists for information assets the same level of scrutiny and compliance should be applied. A corporate risk will be submitted with the recommendation of a strategic options appraisal for Board consideration and within this the role of Informatics as a Directorate will be considered along with other corporate and clinical divisions.	31/12/2021	N/A	N/A	Overdue	4	#VALUE!		November 2021 Update: The Health Board has engaged Templar to review the Information Asset owners, compliance and current risk and this work will be taken forward with the Office of the SIRO to be established as part of the overarching objectives.				07/05/2022	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R3 Management should consider enhancing the risk management process in place within the Health Board by providing an annual report that identifies risks that have a low likelihood, have a severe worst-case scenario. This would ensure that executives are aware of the risks and worst cases that are being managed at a lower level, but hold the potential for severe adverse effects should they materialise.	Accepted. Part of the new governance will focus on the objectives of the CDO as SIRO for the Health Board. Following the review and adoption of the Target Operating Framework and HB exec oversight a programme will commence to adopt new policies, training and performance management of ICT and Information Asset including training for Information Asset Owners.	31/03/2022	N/A	N/A	Overdue	1	#VALUE!		November 2021 Update: The Templar Cyber risk report has been presented to the Digital Oversight Board and scheduled to go to Exec team and future board briefing and the to consider the implementation of the Office of the SIRO				07/05/2022	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT	ADI Governance and Assurance	N/A	R4 The risk identification process should be formally linked to the issue / event / problem management process in order to ensure that underlying risks are identified.	A review of risk management processes has commenced. The Health Board has appointed a Chief Nursing Information Officer/Clinical Safety Officer who will lead the project to align risk management processes from Programmes, design, Service Delivery, Health Records and Information Governance and Cyber Security to inform the new governance structure.	31/12/2021	N/A	N/A	Overdue	4	#VALUE!		**May 2022**:•Training has been provided to several members of the directorate to support the management of risks within programmes and projects. Engagement with the HB overarching risk management functions continues to assess the impact of the introduction of the Once For Wales Risk Management System will have upon the directorates risk management strategy. The strategy is still in draft form whilst operational processes are in development to ensure alignment and appropriate operationalisation of the strategy facilitated.				07/05/2022	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R5 The Health Board should ensure greater links with divisions and the Informatics Directorate. The Informatics Directorate should be involved in the decision making process for all IM&T items.	Accepted. The CDO will present the recommended Target Operating Model to the HB which will include governance over Informatics as a Division and also departmental systems. Part of the framework will include decisions to procure and assurance processes not	31/03/2021	N/A	N/A	Overdue	13	#VALUE!						07/05/2022	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R7 A review of the current strategic position of the Health Board in relation to its digital provision and maturity across all domains should be undertaken.	Partially accepted. The Health Board commissioned a review of the Health Boards capacity and capability to deliver the strategy with recommendations for the Board to consider. This was scheduled for Q1 2020/21 but supporting the Health Board through the pandemic became the priority. Whilst this was not a self assessment against a maturity model as in NHS England or HIMMS it provides a comprehensive framework. The report also makes recommendations about the principle of "Once for ABUHB" which if accepted will lead to a baselining of assets, processes and convention outside of the current Informatics Directorate footprint. The recommendations from the planning of the new operating framework are planned to be delivered to Exec Team Q1 and Board Q2 2021.	30/09/2021	N/A	N/A	Overdue	7	#VALUE!		November 2021 Update: A paper is being drafted for Digital Delivery Oversight Board scheduled in Jan 22 to meet the recommendations of the report with associated costs.				07/05/2022	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT	CDO	N/A	R8 An assessment of the changes needed to implement the Digital Strategy should be undertaken, and the benefits of the changes articulated, along with the consequences of no change. The Health Board should develop a single roadmap to help deliver the Digital Strategy.	As part of the review Informatics has accepted the need for P3O Portfolio management. This work is ongoing and with an initial focus to core Informatics Division activity but provides a framework for Health Board oversight and transparency. The portfolio approach will extend subject to Board approval to all information assets in a planned programme of work. This forms part of the recommendations to Execs in Q1 2021.	30/06/2021	N/A	N/A	Overdue	10	#VALUE!		**May 2022:** Significant work has been undertaken to develop an informatics wide portfolio register to determine LIVE and emerging project work. Further development underway to include dependencies and key project milestones dates. Some funding in place and posts filled, further investment detailed in Target Operating Framework cost model to support roadmap. November 2021 Update: The establishment of a small PMO within Informatics, aligned to P3O Portfolio Management, has progressed in recent months with the permanent				07/05/2022	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT	CDO	N/A	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	N/A	N/A	Overdue	7	#VALUE!		**May 2022**: cost model submitted, seeking to deliver strategy end of Q1/23 November 2021 Update: A paper is being drafted for Digital Delivery Oversight Board scheduled in Jan 22 to meet the recommendations of the report with associated costs. This includes the recommendation for Business partner roles to propogate a network of champions.				07/05/2022	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R10 The Informatics Directorate budget should be set to reflect the actual need of the organisation. Where funding cannot be fully granted, the impact on the underfunded position of Informatics work and Digital Strategy delivery should be clearly stated and agreed with Executives.	Agreed. The Portfolio approach and executive oversight governance will provide the framework in which difficult prioritisation decisions must be taken to avoid historical best endevours approaches. Part of the recommendations from the review of informatics in ABUHB is to establish a dedicated Digital Investment Panel which will provide performance management and oversight to investments in digital. The Health Board recognises the need to prioritise and invest in order to deliver benefits and supports the principle of a benefits management realisation framework and strategy. Budget setting is taking place for next financial year with the aim to agree a growth commensurate with strategic objectives. The Target Operating model is designed to ensure capacity and capability of Informatics is fit for purpose and is currently being costed to inform a case for consideration.	01/10/2021	N/A	N/A	Overdue	7	#VALUE!		November 2021 Update: A final internal challenge session is scheduled for December within the Division to ensure capacity and capability meets the Health Board requirements and will be presented in January 22 to the Digital Delivery Oversight Board before returning to Exec Team.				07/05/2022	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	R11 The Informatics Directorate should develop an overarching workforce plan that sets out the resource gaps together with the skills gaps and how they are to be resolved. The plan should consider apprenticeships, coordinated departmental development and partnerships in order to maximise the use of limited financial resource.	Planning despite COVID continued on the Operating Framework based on existing mandate and footprint of Informatics portfolio. This addresses key areas of competencies and capacity. This has been supported activity with HR & OD and Finance. The new structure proposal reflects the Digital Strategy and Operating Framework but will require scrutiny challenge and approval.	30/09/2021	N/A	N/A	Overdue	7	#VALUE!		November 2021 Update: The Informatics service is engaging iwith Health Education and Improvement Wales to further develop Health Informatics apprenticeship pathways from entry level. The service is actively engaged with HR &OD, Finance colleagues to ensure the best route to recruitment and retention of staff. The TOF provides the resoure/skills gap that currently exists and the resource requirement to support it.				07/05/2022	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT	CDO	N/A	R12 Once the team has been re-established, the key security tasks should be in place:•regular review of firewall rules;•regular vulnerability testing; and•development of a security incident response plan.	Accepted. Active recruitment has been taking place with a Cyber Security Team leader successfully recruited. Emergency Planning colleagues have been collaborating with the cyber teamand the Health Board has contracted with specialist consultancy to accelerate the development of a Information Risk and Cyber Security operating model. Work will commence Q1 including cyber resilience and response plans.	31/12/2021	N/A	N/A	Overdue	4	#VALUE!		**May 2022**: contract awarded to consultancy Mar 2022 to implement recommendations - Office of the SIRO / delegated letters of authority to all information asset owners. November 2021 Update: The Informatics service has engaged a specialist company, Templar to review the current Cyber arrangements and the specific Information Security requirements that need to be addressed. This report has been provided to the Exec Team and there will now be further engagement to ensure that the recommendations are addressed and the				07/05/2022	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT	CDO	N/A	R13 Critical assets should be identified within the asset and configuration management systems.	Agreed. This in part is due to the devolved nature of informatics.The first step will be presenting the new operating framework's overarching governance recommendations will provide oversight. A strategy, policy and resultant business case will be developed following the Health Board adoption of the reviews recommendations.	31/12/2021	N/A	N/A	Overdue	4	#VALUE!		November 2021 Update: This is dependent on the TOF being implemented and the business analysis to be conducted to provide this input into an asset management system				07/05/2022	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT	CDO	N/A	R14 The asset and configuration management processes developed within the Informatics Directorate should be adopted as Health Board wide documents and departments with devolved control required to comply with the requirements.	Accepted. The HB governance, policy and processes will be reviewed as part of the SIROs objectives with resultant recommendations to Board. Informatics will need to review internal processes and capacity to ensure it can scale to meet the challenge.	31/12/2021	N/A	N/A	Overdue	4	#VALUE!		May 2022: contract awarded to consultancy Mar 2022 to implement recommendations - Office of the SIRO / delegated letters of authority to all information asset owners November 2021 Update: A report commissioned by the Health Board has been presented at the Digital Delivery Oversight Board and accepted. A proposal on next steps will be presented with associated costs to Executive Team in Q3 2021				07/05/2022	
	Internal	High Voltage Electrical System Management (2020/21)	Reasonable	Director of Operations	Head of Estates (Maintenance & Operations)	Medium	R1 The function and membershipsof the Statutory Compliance Group and Electrical Safety Sub-Group should be reviewed to ensure:a)Both groups meet with the required frequencies set out in their Terms of Reference; b)Responsibilities and memberships across the two groups meet the recommendations of WHTM 06-01;c)Anelectrical-specific Terms of Reference, or as a minimum, a standard agenda, is developed for the Electrical Safety Sub-Group and approved by the SCG;d)Awritten report be submittedby the ESSG to each SCG meeting, providing assurance on thekey areas of compliance required byHTM 03; ande)Minutes from all meetings should be retained for future reference, in line with the UHB's agreed document retention policy and WHTM/HTM requirements (O).	Agreed. The next meeting of the ESG has now been scheduled for 24th March 2021.	30/06/2021	N/A	N/A	Overdue	10	#VALUE!						07/05/2022	
	Internal	High Voltage Electrical System Management (2020/21)	Reasonable	Director of Operations	Head of Estates (Maintenance & Operations)	Medium	R3 a)An audit / recommendation tracker should be put in place, to monitor the status of compliance-related recommendations received.b)Progress should be monitored at the Electrical Safety Sub-Group (and other sub-groups as appropriate),and reported to the Statutory Compliance Group(O).	Agreed, an action tracker will be implemented. We recognise this may also facilitate funding allocations.	30/06/2021	N/A	N/A	Overdue	10	#VALUE!						07/05/2022	
	Internal	High Voltage Electrical System Management (2020/21)	Reasonable	Director of Operations	Head of Estates (Maintenance & Operations)	Medium	R6 Limitation of Access forms should be used where appropriate for work undertaken by the maintenance contractor (e.g. circuit breaker protection trip testing) (O).	Agreed. Appropriate documents will be in place from now onfor relevant works.	30/04/2021	N/A	N/A	Overdue	12	#VALUE!						07/05/2022	
	Internal	High Voltage Electrical System Management (2020/21)	Reasonable	Director of Operations	Head of Estates (Maintenance & Operations)	Low	R2 The NWSSP: SES website should be periodically checked to ensure Works & Estates are in receipt of all relevant hazard notices(O).	Agreed, the website will be periodically checked from now on. The omission was not the fault of the UHB, and further we would normally expect input from NWSSP:SES to provide additional assurance in this area. Under normal circumstances, we would also monitor alerts for reporting to the Statutory Compliance Group / ESG (as discussed	30/04/2021	N/A	N/A	Overdue	12	#VALUE!						07/05/2022	
	Internal	High Voltage Electrical System Management (2020/21)	Reasonable	Director of Operations	Head of Estates (Maintenance & Operations)	Low	R4 a)Operational Procedure and Operations & Maintenance files should be reviewed, with out of date documents archived and current documents filed, as required by HTM 06-03.b)Site/substation log books should be maintained in the format required by HTM 06-01 (section 8).c)Records of inspections / replacement of equipment for which the UHB is responsible for should be maintained in the HV	Agreed, we recognise the benefits of improved record keeping, to make current documents more accessible.	30/06/2021	N/A	N/A	Overdue	10	#VALUE!						07/05/2022	
	Internal	High Voltage Electrical System Management (2020/21)	Reasonable	Director of Operations	Head of Estates (Maintenance & Operations)	Low	R5 The UHB's HV policy requirement for inclusion of specific wording on the Limitation of Access forms should be reviewed, and removed if no longer considered feasible / necessary (D).	Agreed. We have reviewed the policy and agree the reference will be removed.	30/06/2021	N/A	N/A	Overdue	10	#VALUE!						07/05/2022	
	Internal	Clinical Futures - Workforce (2020/21)	Substantial	Director of Workforce & OD		Medium	R1 The Health Board should reinstate the completion of the Action and Delivery Frameworks to assist in the delivery of the IMTP objectives.	It is acknowledged that the monitoring of the WOD IMTP Objectives and milestones changed during the pandemic. The WOD function is planning on introducing a revised internal monitoring process in line with the 2021 People Plan which will be aligned to the Health Board's approved Annual Plan.	31/01/2022	N/A	N/A	Overdue	3	#VALUE!		**April 2022** A draft Delivery and Monitoring Framework has been developed to support the implementation of the People Plan 2022-2025. The Framework includes governance and assurance which will be overseen by the People and Culture Committee - pending final agreement and sign off				07/05/2022	
	Internal	Management of Balance Sheet Assets (2018/19)	Reasonable	Director of Finance, Procurement & Value	Head of Capital Finance	High	R1 The Health Board should introduce tagging / identity marking of all relevant assets.	Agree the Recommendation.For clarification, whilst capital assets are not tagged with the individual Fixed Asset Register number, a significant proportion of assets are tagged by other departments such as Medical Electronics and IT. Current processes involve the asset register being updated with serial numbers and the appropriate Medical Electronics reference, however, this information is not available for all historic assets.To improve the security of assets, and identification as part of the annual verification process, the Capital Team will, in consultation:Develop a policy for asset tagging which defines where tagging is appropriate;Investigate options for the purchase of an asset tagging system, considering existing systems in use in ABUHB and potential for linking to the Medical Electronics database and research the systems employed at other health boardsand trusts;Develop a business case and plan for the implementation of a preferred option in 2019/20 including outline specification, cost/benefits analysis, procurement options, funding	31/03/2020	N/A	N/A	Overdue	25	#VALUE!		November 2021 Update: Training sessions held, software integration issues remain - meeting to resolve to be held on 29th October 2021. Tagging on-going and full live roll out will be implemented once integration resolved.				07/05/2022	
	Internal	Well-being of Future Generations (Wales) Act 2015 (2018/19)	Reasonable	Director of Public Health and Strategic Partnerships		High	R1 The Wellbeing of Future Generations Act Programme Boardshould include a review of the objectives and the progress against them as part of itsagenda, to ensure objectives are fit for purpose and the activities required to meet them are identified and monitored. 2) EachProgramme Board should be chaired by the Executive Lead in order to provide leadership, monitor effectivenessand highlight the importance of attendance. 3) Poor attendance at the Programme Board should be taken forward by the Executive Lead in order to ensure that it is rectified.	Agreed1.Thereview of the Wellbeing Objectiveswill be undertaken in conjunction with a broader review of where these objectives sit in the context of other Organisational priorities and ambitions. A landscape review/mapping of these various aspects will need to be undertaken in conjunction with the ABUHB Planning Teamtoinform the review of Well-being Objectivesas part of the IMTP process.The Programme board will include a review of progress against objectives as part of its agenda. 2.Programme Board meetings will be moved from a monthly to a quarterly basis and will be chaired by the Executive Director of Public Health and Strategic Partnerships. This will be	31/12/2019	N/A	N/A	Overdue	28	#VALUE!		April 2022 Update: the review of the Wellbeing objectives continues to be put on hold due to the prioritisation of the response to the Covid-19 pandemic. ABUHB is actively engaged in the process to agree a new collective set of Gwent PSB Wellbeing Objectives which will subsequently inform the review of the ABUHB Wellbeing Objectives'				07/05/2022	
	Internal	Health and Safety (2017/18)	Limited	Director of Therapies & Health Science	Head of Health and Safety	High	The Health Board should develop a methodology / approach for establishing and undertaking an annual programme of workplace inspections. In particular, it should set out:how service areas / wards are selected for an inspection, including risk analysis, previous findings, incidents and Datix reporting;the approach to the inspection, including which health and safety areas are included. For example, there may be numerous priorities from one year to the next;methodology for undertaking the inspection, i.e. the process for completing one from start to finish;how assurance is provided to the sub-committees of the Board over how the programme of work is devised and that it is completed on schedule or otherwise; andfindings from the workplace inspections are identified and acted upon.In addition, the Health Board should ensure that a programme of workplace inspections is developed and delivered in accordance with section 10.1 of the Occupational Health and Safety Policy. For example, the Health and Safety Committee may stipulate that all high risk areas are reviewed each year. Furthermore, if the programme is delivered late, then the Committee should receive assurances, together with an action plan for delivery to be returned to schedule.	An ABUHB health and safety monitoringmanual will be developed. This will include a two year plan which outlines the audit/inspection delivery programme.The manual, including programme willbe presented at the ABUHB Health and Safety Committee in March 2018 for approval. The anticipated start date of the monitoring is 1stApril 2018.Future monitoring of the health and safety audit/inspection compliance will be presented via Divisional dashboards with an overview being presented at the ABUHB Healthand Safety Committee.	30/04/2018	N/A	N/A	Overdue	48	#VALUE!		November 2021 Update: the position has not changed since the last update in August 2021, however, a meeting is planned with colleagues in the Facilities Division this month to work collaboratively to develop a health and safety monitoring programme. The programme will include H&S management audits, thematic audits and 'walk the ward' inspections. The roll out of the new programme is planned for April 2022. In addition to this we are also planning the development of self-assessment inspection tools for wards and departments to be				07/05/2022	
	Internal	Health and Safety (2017/18)	Limited	Director of Therapies & Health Science	Head of Health and Safety	High	The Health Board should ensure that each area has completed an up-to-date health and safety risk assessment, by a trained co-ordinator. The risk assessment process should be overseen by the Health and Safety team, to ensure that it is completed in accordance with the Occupational Health and Safety Policy.In addition, the Health Board should review and refresh the list of safety co-ordinators and continue to do so following the initial update.The Health and Safety team should provide assurance and regular updates to the Health and Safety Committee over the status of risk assessments.	The monitoring of local risk management systems, including risk assessments will be included in the audit/inspection programme.The status of risk assessments will be reviewed and compliance reported via a dashboard to the ABUHB Health and Safety Committee and relevant Divisional forums.Further consideration is required to the utilisation of software to record and manage risk within the Health Board.	30/04/2018	N/A	N/A	Overdue	48	#VALUE!		August 2021: Due continued demands and impact from the pandemic within the Corporate Health and Safety Department the programme of health and safety monitoring has not re-started. However, monitoring has been conducted relating to COVID Safety				07/05/2022	
	Internal	Pay Incentives (2019/20)	Limited	Director of Operations		High	R1 The Health Board should restrict additional session payments to standard levels, but where this is not possible; maintain an approved schedule of enhanced rates ratified by the Executive Team with appropriate justification / reasoning included. The schedule of enhanced rates should be reviewed frequently e.g. every three months.	Approval to continue paying WLI rates from Executive Team – taken forward to RATS Committee. Review as part of IMTP demand and capacity discussions each year.	30/09/2019	N/A	N/A	Overdue	31	#VALUE!		November 2021 Update: Rate card has been revised and drafted across all divisions and will be shared and signed off by the Divisonal Director's with a view to sign of at Execs for the end of November, with the				07/05/2022	
	Internal	Pay Incentives (2019/20)	Limited	Director of Operations		High	R2 In relation to the non-automated process only, consultants should submit signed claim forms for all additional sessions they are claiming payment for, listing appropriate details in respect of session dates, start/ finish times etc. and including a declaration that all sessions claimed are in addition to contracted work. The submitted claim form should be reviewed, validated and checked for accuracy before any payment is made.	Agreed. Executive Team will agree the approved system for claiming for all additional sessions and communicate with the Health Board. This must simplify the process for claiming to maximise compliance.	30/09/2019	N/A	N/A	Overdue	31	#VALUE!		April 2022 Temporary additional sessions for Consultants and SAs staff are agreed as part of the job planning process and paid at the doctors usual rate and annotated on the job plan proforma.				07/05/2022	
2021.13	Internal	Continuing Healthcare MH&LD	Limited	Director of Primary, Community Care and Mental Health	Divisional Nurse	Medium	R2.1 Clarity should be provided in terms of the roles and responsibilities of the Commissioning Team and the Care Coordinators, particularly associated with annual reviews.	2.1 The respective roles and responsibilities of the Commissioning Team members and Care Coordinators will be reinforced, ensuring clarity.	31/03/2022	N/A	N/A	Overdue	1	#VALUE!						07/05/2022	07/04/2022

ABUHB	Audit Type	Report Title	Assurance	Director	Responsible	Ref /	Recommendation	Management Response	Agreed	Revised	Revised	Due	No. of	No. of months	If closed	Progress being made to implement recommendation				Reporting Date	Date Added to
	Internal	IT Service Management, May 2018	Limited	Director of Planning, Digital & IT	Associate Director of Informatics	High	R3 Informatics should seek to develop a SKMS in order to share knowledge across departments. This process should include developing a Knowledge Centred Service (KCS) process within the service desks and ensuring models for calls and problems are catalogued and indexed and easily available.	AcceptedWe recognise that this is a priority and that Service Point does not meet the needs of the service to develop the KCS (also identified by this audit) and therefore, Informatics will undertake a scoping and options appraisal exercise to define the requirements, including the resource needed.A business case has been developed for ICT only that seeks to address the concernswithin ICT; this work will inform the requirements of a similar review for Informatics.	31/10/2018	Feb-22	Jan-19	Overdue	**42**	3		**May 2022** update: A comprehensive SKMS has now been implemented comprising a knowledge base with c. 1000 articles, a fully indexed and searchable shared document repository and a service catalogue of all Informatics services, fully described for our key services. All areas are cross linked based on Service. Propose that this item can be closed November 2021 Update: Existing knowledge artefacts have been migrated to share point online and are fully searchable and available across Informatics teams. A review of			Implement revised information architecture Define and Implement governance around permissions, review timescales and formats for new artefacts Establish links to service catalogue Ensure criteria for SDI Audit are met	07/05/2022	
	Internal	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory Report)*	Not Rated	Board Secretary		N/A	R1 The Health Board should ensure it clearly documents roles and responsibilities in its governance structures and plans.	Not included within advisory report	31/12/2021	Mar-23	N/A	Deadline Revised	**4**	-11		Accountability & Deployment Framework Included as a governance priority within the IMTP 2022-25				07/05/2022	
	Internal	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory Report)*	Not Rated	Board Secretary		N/A	R3 The Health Board should clearly document reporting requirements within its governance structures and plans, at each level of the organisation. This should include:i.expected frequency of reporting;ii.level of detail / assurances expected;iii.type of reporting expected, for example, tracking progress, reporting by exception, monitoring key metrics or performance indicators (KPIs), etc;iv.nature of the reports expected, for example, verbal, formal, set template, etc;	Not included within advisory report	31/12/2021	Mar-23	N/A	Deadline Revised	**4**	-11		Accountability & Deployment Framework Included as a governance priority within the IMTP 2022-25				07/05/2022	
2021.02	Internal	Gifts, Hospitality and Declarations of Interest	Reasonable	Board Secretary	Board Secretary	Medium	R1 The Health Board should add an additional section to the declaration of interests form detailing any additional action required to mitigate risk. These measures should be implementedand monitoredby the individual's line manager.b.The Policy and accompanying processes should be updated to support the changes required to mitigate the risk.	a.As identified, whilst there is adherence to the policy, the recommendation provides an opportunity to improve the mechanismswithin departments. To facilitate this the Health Boards ESR will be reviewed to determine how declarations can be digitally captured toenable improved conflictmonitoring and management.Where ESR may not be used (e.g. by Independent	31/10/2021	Mar-23	N/A	Deadline Revised	**6**	-11		Arrangements for the declaring of interests, gifts and hospitality Included as a governance priority within the IMTP 2022-25				07/05/2022	25/03/2022
2021.01	Internal	Gifts, Hospitality and Declarations of Interest	Reasonable	Board Secretary	Board Secretary	Medium	R2 The procedures for receiving and processing declarations made should be formalised and include:i.the use of a shared mailbox for all declarations;ii.details of the process for receiving and processing declarationsand the associatedtimescales;iii.details of due diligence to be undertaken on completed declarations;iv.timeframes for reminders to be issued in the event where previous declarations have been submitted; andv.details of any completeness checks to be undertaken to determine if there are missingdeclarations.	To facilitate all recommendationsthe Health Boards ESR will be reviewed to determine how declarations can be digitally captured and enabled toimprove receipt and management. This will facilitate improved recording across the organisation, allow automated reminders, and provide reports to Divisional managers for completion and adherence checks and missing declarations.In addition, where ESR may not be used (e.g. by Independent Members) then the manual form will be updated to reflect the recommended improvements.	31/10/2021	Mar-23	N/A	Deadline Revised	**6**	-11		Arrangements for the declaring of interests, gifts and hospitality Included as a governance priority within the IMTP 2022-25				07/05/2022	25/03/2022
2021.07	Internal	Occupational Health	Substantial	Director of Workforce & OD	Director of Workforce & OD	Low	R2 The Health Board should consider:a)Automating key aspects of the processes, to reduce the workload for the Occupational Health Team. For example, auto-generation of emails / letters for referrals, self-selection of referral appointmentsby staff or a self-directed referral to an appropriate professional.b)Updating resilience / continuity plans to assist with increased demand in the future, to include reallocation of team members, setting up amended work schedules, reduced appointment slots, allocation of clerical staff to clinical staff to maximise clinic availability, overtimeoptions, re-focussing of service prioritiesand / or streamlining of processes to a bare minimumon a temporary basisetc.c)Engaging in any future All-Wales reviews of occupational health serviceswithin the NHS.	a.It is planned that the current management referral process will move from paper referral and Occupational Health response in letter format to an online referral system and subsequent report to managers in 2022. The service is currently part of an All Wales task and finish group developing this. Once implemented it should remove several administration stages of the current process. The recommendation for staff to be able to self–select would miss out the essential clinical triage process to allocate Occupational Health clinical staff resources appropriately.b.Occupational Health consistently review its skill mix and resources to meet the demands of the service. Through periods of higher administration demand for example Covid 19 PCR results and the annual Flu programme additional administrative hours are sourced. This reduces any impact on routine Occupational Health function. A detailed service review is planned for Quarter 2 in 2022 which will incorporate the recommendation of the Occupational Therapy scoping exercise which commenced on the 1stNovember and is planned to conclude on March 31st2022. Health function. A detailed service review is planned for Quarter 2 in 2022 which will incorporate the	31/03/2022	Dec-22	N/A	Deadline Revised	**1**	-8		**April 2022** a. The planned introduction of an online referral process has been halted as a new database is being procured on an all Wales basis. b/c. Welsh Government review of Occupational Health in the NHS is currently being undertaken (April 2022). OT pilot completed and the recommendations are being considered.				07/05/2022	25/03/2022
	Internal	Clinical Audit Follow-up (2018/19)	Limited	Medical Director		High	R1 1.1The Health Board should develop a Quality & Patient Safety Improvement Strategy and Assurance Framework, based upon a reviewofits approach to clinical audit and other QPS assurance mechanisms. This should incorporate an assurance mapping exercise against the organisation's quality and patient safety risk registers, focusing on major clinical risks.Such a Strategy and Framework should bring together the quality and patient safety improvement work undertaken throughout the Health Board, including clinical audit, ABCi, Value Based Healthcare, etc, and explicitly cover:□the Health Board's approach to quality and patient safety improvement;□how this work addresses the Health Board's major QPS risks;□the governance and accountability structures within the organisation that support the delivery of the work; and□the reporting mechanisms to bring this work together to form an overview of QPS improvement work and the assurance it provides to the organisation;□how quality improvement activities comply with information governance legislation; and□howservice users are involved and engaged in quality improvement activity.The Strategy and Framework should either make reference to, or incorporate, the existing strategies for individual elements of quality and patient safety improvement work ongoing throughout the Health Board.1.2The QPSC should formally approve the Quality & Patient Safety Improvement Strategy and Assurance	A Quality Improvement Leaders Group will be set up, with the leaders of ABCi, Value based healthcare, clinical audit and R and D and innovation,toseek todevelop a new way of usingclinical information for improvement and from this, a Quality and Patient Safety Improvement Strategy and Assurance Framework. It will incoprporate a review of known clinical risks and those on the patient safety risk registers, focussing on major clinical risks.From this, the Executive Team will assess the level of clinical audit required by the organisation and the resource needed to support this,in order to undertake the Health Board wide audit above and beyond the NCAORP,ensuring that the clinical audit activity is effective in bringing about improvement.The Medical Education Team will be charged with randomly selecting 100 non-identifiable Consultant re-validationquality improvement domains, to identify the volume and subject of the audit activity in a year. This will be mapped against the broad areas where clinical risk has been identified, not withstanding large scale work undertaken via other QPS improvement mechanisms.	31/03/2020	Sep-22	N/A	Deadline Revised	**25**	-5		The Clincal Audit policy and Framework have been revised and consultation will be comenced on April 25th 2022. The strategy includes the requirement for Divisions and Corporate leads to develop Clincal Audits plans aligned to quality and safety risk with a key set of benchmarks to support this. The Clincal Standards and Effectivenss Group oversees the governance relating to clincal audit and reports biannualy to PQSOC the outcomes and improvements plans relating to national audit.				07/05/2022	
	Internal	Clinical Audit Follow-up (2018/19)	Limited	Medical Director		High	R2 The Health Board is required to participate in a certain level of clinical audit, as noted in section 6. Therefore, it is necessary to have appropriate governance and reporting structures in place to support this. We have set out our recommendations to improve the current structuresfor national and Health Board wide clinical auditbelow.2.1The Clinical Audit Strategy and Policy should be updated to incorporate the recommendations of this review. The QPSC should formally approve the Clinical Audit Strategy and Policy. 2.2The MDST should ensure that relevantstaff are aware of, and adhere to, the requirements of the Strategy and Policy.2.3The MDST should bring together the top twotiers of the clinical audit plan (nationalandHealth Board wide) into one document, 'the Clinical Audit Programme'. TheClinicalAudit Programme should explicitly state which QPS risks it addresses and should be formally approved by the QPSC.2.4Governance mechanisms should be sufficient for the QPSC to regularly monitor delivery of the Clinical Audit Programme. This could be in the form of anoverall summary within the QPSreport that is currently written and presented by the Assistant Director of QPS. The summarycould be in a narrative or dashboard style. .2.5There should be a clearly defined and documented mechanism for the dissemination of results and recommendations throughout the Health Board and the escalation of significant findings to the appropriate forums. Escalation of results could be done via the	2.1-2.6.The Clinical Audit Strategy and Policy will be updated to include the outputs from the recommendations from this review once the process has been completed. This will be approved at Exec Board and QPSC and communicated across the organisation, through dissemination to the Clinical Directors.The MDST will bring together the NCA and health board wide audit into a clinical auditforimprovement programme, through discussion at QPS Operational Group. It will be approved at QPSC.Set up a Clinical Effectiveness and Standards Group('CESG'), chaired by the AMD for Clinical Effectiveness and with ADD representation from all Divisions, which will monitor the delivery of the Clinical Audit for Improvement Programme and monitor the implementation of recommendations. It will receive the results of the NCAs and Health Board Audits and determine which require escalation and reporting to QPSC.2.7. The MDST wil develop over a number of meetings, a report on participation in NCAs within the Quality Performance Report for QPSC.2.8.One to one supporton clinical auditis always available to staffthrough the MDST. The training resources available will be clarified on the Clinical Audit Intranet page.	31/03/2020	Sep-22	N/A	Deadline Revised	**25**	-5		The Clincal Audit policy and Framework have been revised and consultation will be comenced on April 25th 2022. The strategy includes the requirement for Divisions and Corporate leads to develop Clincal Audits plans aligned to quality and safety risk with a key set of benchmarks to support this. The Clincal Standards and Effectivenss Group oversees the governance relating to clincal audit and reports biannualy to PQSOC the outcomes and improvements plans relating to national audit.				07/05/2022	
	Internal	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies & Health Science		High	R1 Registers should be maintained for operational management of medical devices and equipmenton each ward and department, which should record relevant equipment details.The register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed.Each areashould ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record itupon theirregister. Discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded. Going forward, relocation of equipment, disposals, additions etc. should be updated promptly to ensure an accurate record continues.	The Health Board to consider investing in an overarching equipment database register with staff resources to ensure regular updating and management.	31/03/2018	Nov-22	N/A	Deadline Revised	**49**	-7		Radio frequency ID tagging has commenced for all medical devices and will progress throughout 2022 . This will support the management and localtion of all devices including servicing history. Thetares are developing a register of all medical devices.				07/05/2022	
	Internal	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies & Health Science		High	R2 A clear robust control mechanism should be established by the divisions / directorates demonstrating the consideration and delivering of applicable training,aligned to medical equipment and devices. Training records should also be uploaded onto ESR.The poor mandatory training compliance rates with regard to infusion devices / pumps should be addressed as a matter of urgency.	From a Divisional perspective, the cascade training provided at ward level has not raised any particular safety issues, although with the increasing use of bank and agency staff, consideration should be given to accessible on site training for these members of staff. The Health Board to consider establishing a catalogue of equipment that needs specific training to operate, alongside a database of staff compliance.	31/03/2018	Jun-22	N/A	Deadline Revised	**49**	-2		An infision device training strategy was presented to the April Medical devices Committee. A training implementaion plan is now under development to support the roll out of a more resilient process in line with the strategy .				07/05/2022	

ABUHB	Audit Type	Report Title	Assurance	Director	Responsible	Ref /	Recommendation	Management Response	Agreed	Revised	Revised	Due	No. of	No. of months past	If closed	Progress being made to implement recommendation	Reporting Date	Date Added to
	Internal	Job Planning, March 2020	Limited	Medical Director	Interim Director of Operations	High	R1 The Health Board should: · review the escalation process to ensure that it includes appropriate action following escalation to the Medical Director and holds medical staff to account for failure to have an in date job plan; · produce action plans to address poor compliance and review these as part of the monthly divisional meetings with the COO; · complete job plans on an annual basis, as opposed to a 15-month cycle. · consider the process for reviewing job plans and look at ways of increasing compliance, such as aligning job planning dates with other activities (i.e. IMTP /Corporate Planning cycle); and; · agree the job plan and implement an escalation / disciplinary process if there is not a legitimate reason for failure to agree a job plan.	Medical Director to formally write to all DDs with the outcome of this Internal Audit.Escalation Process will be refined giving timelines for response by DDs to Medical Director escalation.Tracker of escalations to be maintained by Medical Directors office.	01/03/2020	N/A	N/A	Complete	**26**	#VALUE!		April 2022 Update: R1 - Escalation Process reviewed. Removal of 15 months compliance. Continue to performance reporting and inclusion in workforce dashboard. Consider annual cyle to IMPT process was discounted. R2 - Reissued proforma and communicated responsibilities. Distance learning pack available includes pro forma and available on intranet. R3 - SMART objectives included in distance learning pack. R4 - UnSigned agreed Job Plans are returned for signature (electronic email accepted) R5 - Local management teams are consistently reminded of the need to inform payroll of any changes in sessions or intensity suppliments. Additionally information: Executive	07/05/2022	
	Internal	Mass Vaccination Programme, April 2021	Substantial	Director of Public Health and Strategic Partnerships	Deputy Director of Public Health	Medium	R1 The Health Board should review:•how it engages with members of the public who do not have access to the internet; and•advertising the telephone number for the appropriate appointment booking team.	The need to review how the Health Board engages with members of the public who do not have access to the internet is accepted. As part of that review, the Health Board will consider advertising the telephone number and whether the significant operational implications of doing so can be overcome. If advertising the number continues to be too big a risk to the pace of delivery of the programme, alternative options will be provided.	30/06/2021	N/A	N/A	Complete	**10**	#VALUE!		The audit was in April 2021 in the early stages of the programme. Since then a lot of effort has gone into reaching those who have not yet taken up the offer through a range of communication routes including call outs to those who think they are overdue, walk in clinics, local community engagement though community leaders and	07/05/2022	
	Internal	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory Report)*	Not Rated	Board Secretary		N/A	R2 Where possible, the Health Board should endeavour to incorporate accountability,reportingand assurance into existing structures, rather than as additional processes which are not sustainable in the longer term.Using the example of the CIP, going forward this could include:i.accountability,reportingand assurancethrough the existing quality and patient safety governance mechanisms;ii.reporting integrated into existing divisional/site-based reports; andiii.CIP compliance assurance integrated into the divisional/site-based clinical audit plans.	Not included within advisory report	31/12/2021	N/A	N/A	Complete	**4**	#VALUE!		Noted for future governance models.	07/05/2022	
	Internal	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory Report)*	Not Rated	Board Secretary		N/A	R4 Where KPIs or data-driven reporting is used, the Health Board should ensure:i.the data is accurateand can be efficiently accessed; andii.KPIs are presented consistently between the divisions, for example, by clearly defining how KPIs are calculated.	Not included within advisory report	31/12/2021	N/A	N/A	Complete	**4**	#VALUE!		Noted for future reporting requirements.	07/05/2022	
	Internal	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory Report)*	Not Rated	Board Secretary		N/A	R5 The Health Boardshould consider developinga protocol pack for any future surges of the pandemic.This could be implicit within the Health Board's pandemic framework and include, for example:i.Formally identifying governance structures for different surge levels;ii.For each governance structure, identifyinggroups that are required to meet, with clearly documented terms of reference identifying:a.roles and responsibilities;b.anticipated membership, including leadership of the group;c.frequency of meetings;d.reporting requirements (see recommendation6below);ande.records required to demonstrate monitoring, scrutiny and decision-making, for example, minutes, action log, decision log, etc(see recommendation4below).This should take into accountrecommendation 2 above.	Not included within advisory report	31/12/2021	N/A	N/A	Closed	**4**	#VALUE!		Response would vary dependent on type of variant and impact. Learning from the pandemic is embedded in new ways of working.	07/05/2022	
	Internal	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory Report)*	Not Rated	Board Secretary		N/A	R6 The Health Board should ensure meetingminutes appropriately demonstrate monitoring, scrutiny,decision-makingand assurance, particularlyif reporting isinformal /verbal.	Not included within advisory report	31/12/2021	N/A	N/A	Complete	**4**	#VALUE!		Noted as a principle of good governance.	07/05/2022	
	Internal	Covid-19: Reducing Nosocomial Transmission April 2021 *(Advisory Report)*	Not Rated	Board Secretary		N/A	R7 When developing action plans, the Health Board should ensure:iii.the plans contain clear timescales and milestones;iv.clarity is provided on demonstrating progress, for example, RAG rating definitions and requirements for validating progress; andv.benefits and key metrics are defined within the plan.	Not included within advisory report	31/12/2021	N/A	N/A	Complete	**4**	#VALUE!		Noted as a principle of good governance.	07/05/2022	
	Internal	Staff Experience June 2021 *(Advisory Report)*	Not Rated	Director of Workforce & OD		N/A	R1 The Health Board should assist staff in locating the most appropriate resources for their wellbeing needs. For example, a categorisation of the range of wellbeing concerns or requirements through to automated questioning on the website to direct staff promptly.	A review of categories of well-being support will be undertaken to ensure staff can readily locate the support that best fits their need.	31/03/2022	N/A	N/A	Complete	**1**	#VALUE!		April 2022 A review of categories of well-being support will be undertaken to ensure staff can readily locate the support that best fits their need. Our understanding of the wellbeing needs of the workforce is evolving as it is based in part on our 4 monthly wellbeing survey. As such we regualry review what support we offer in line with demdn and changing needs.	07/05/2022	
	Internal	Staff Experience June 2021 *(Advisory Report)*	Not Rated	Director of Workforce & OD		N/A	R2 The Health Board should assist staff in locating the most appropriate resources for their wellbeing needs. For example, a categorisation of the range of wellbeing concerns or requirements through to automated questioning on the website to direct staff promptly.	This would not be an appropriate response to a clinical intervention from a specialist as each intervention is preceded by a clinical assessment to ascertain the most appropriate intervention for that individual based on their particular circumstances. What is suitable for one client may not be suitable for another (despite their reason for referral appearing the same).However, the team will review a system of describing what others found helpful. This will enhance the current offer of feedback and satisfaction questionnaires completed by staff following an intervention. The development of an evaluation framework that has commenced with Cardiff Metropolitan University to evaluate the implementation of the Well-being Centre of Excellence will also support this recommendation.	31/03/2022	N/A	N/A	Complete	**1**	#VALUE!		April 2022 This would not be an appropriate response to a clinical intervention from a specialist as each intervention is preceded by a clinical assessment to ascertain the most appropriate intervention for that individual based on their particular circumstances. What is suitable for one client may not be suitable for another (despite their reason for referral appearing the same).However, the team will review a system of describing what others found helpful. This will enhance the current offer of feedback and satisfaction questionnaires completed by staff following an intervention. The development of an evaluation framework that has commenced with Cardiff	07/05/2022	
2021.11	Internal	GUH – Equipment Procurement Assurance - Follow up	Reasonable	Director of Planning, Digital & IT	Project Director	Medium	Management should ensure the ability to utilise "as fitted" water configuration diagrams (e.g. via rights to utilise third party software, or procured software).	Lessons learnt from equipment has been picked up as part of the broader lessons learnt report but a review by procurement alongside other projects would be beneficial.	31/12/2021	N/A	N/A	Complete	**4**	#VALUE!		Noted for future procurement	07/05/2022	25/03/2022
2021.11	Internal	GUH – Equipment Procurement Assurance follow - up	Reasonable	Director of Planning, Digital & IT	Project Director	Low	R7 Single Tender / Single Quotation Actions should be reported to the Audit Committee in a timely manner, in line with SFIs, to enable effective scrutiny (O).	Agreed, all outstanding STAs will be taken to the next Audit Committee.	31/12/2021	N/A	N/A	Complete	**4**	#VALUE!		All outstanding STA's present to Audit Committee Dec 2021. Central process in place to ensure reporting of STAs to Audit, Risk & Assurance Committee	07/05/2022	25/03/2022
2021.06	Internal	Mental Capacity Act	Reasonable	Director of Nursing	MCA Lead/Head of DOLS	Low	R1 We recommend that procedural documents that have passed their stated review date are updated where required to reflect current legislation.	Agreed This procedure will be reviewed and updated with pace.	30/11/2021	N/A	N/A	Complete	**5**	#VALUE!			07/05/2022	25/03/2022
2021.06	Internal	Mental Capacity Act	Reasonable	Director of Nursing	Head of MCA	Medium	R2 We recommend that the 'best interests' discussion for patients assessed as lacking capacity is documented in the designated pages of the capacity assessment document in all cases.	Agreed A reminder will be issued across the organisation regarding robust completion of documentation.	30/11/2021	N/A	N/A	Complete	**5**	#VALUE!			07/05/2022	25/03/2022
2021.06	Internal	Mental Capacity Act	Reasonable	Director of Nursing	Head of MCA	High	R3 We recommend that, excepting where there is no reason to doubt that the patient has capacity, DNACPR decisions forms are accompanied by completed Health Board patient capacity assessment forms in all cases.	Agreed A reminder will be issued across the organisation regarding completion of DNACPR and Capacity Assessment forms.	30/11/2021	N/A	N/A	Complete	**5**	#VALUE!			07/05/2022	25/03/2022
2021.06	Internal	Mental Capacity Act	Reasonable	Director of Nursing	Clinical Executives	Low	R4 The All Wales DNACPR policy must be complied with in full without exception. We recommend that succinct but sufficient details of patient or relatives' discussions are recorded on the All Wales DNACPR forms in all casesin order to ensure that the policy is complied with.	Agreed Correspondence will be sent to clinicians outlining the importance of detailing discussions with relatives.	31/12/2021	N/A	N/A	Complete	**4**	#VALUE!			07/05/2022	25/03/2022
2021.06	Internal	Mental Capacity Act	Reasonable	Director of Nursing	Head of MCA	Medium	R5 We recommend thatmanagement remind ward staff conducting capacity assessments of the need for competency in this area and that theyseek competency status from each relevant member of staff and if necessary ensure that relevant training is accessed and completed.	Agreed Correspondence will be issued to Divisions, for cascade, highlighting the training available.	30/11/2021	N/A	N/A	Complete	**5**	#VALUE!			07/05/2022	25/03/2022
2021.03	Internal	Clinical Negligence	Substantial	Director of Nursing	Head of Legal Services	Low	R1 Management should update the policies and procedures available to staff on the intranet and ensure only those that are in date and reflect current practice are maintained.	Agreed.Outdated Policies will be removed & existing policies will be updated to reflect changes to WRP and portfolios.	31/12/2021	N/A	N/A	Complete	**4**	#VALUE!			07/05/2022	25/03/2022
2021.03	Internal	Clinical Negligence	Substantial	Director of Nursing	Director of Nursing	Medium	R2 Before payment is processed,clinical negligence cases which have damages in excess of £100k,mustprovide evidenceas having been approved by the LitigationGroup. Where payment needs to be made before the next Group meeting and the Group is unable to reconvene before this date, the Legal Services Team should issue an email to the members of the Group informing them payment will be made before the next meeting and any objections to this payment should be identified immediately. Additionally, the BACs payment sheet should be updated to include the date the case will be brought to the Litigation Group for retrospective approval. This should serve as one of the final checks prior to payment.	Agreed for immediate action	15/12/2021	N/A	N/A	Complete	**5**	#VALUE!			07/05/2022	25/03/2022
2021.02	Internal	Putting Things Rights	Reasonable	Director of Nursing	Assistant Director of Nursing	Medium	R1 Divisions should provide assurance that actions arising from a complaint investigation areaddressed,with ongoing monitoring, depending on the significance of the action. Upon the introduction of the Once for Wales concerns management system, all complaint actions should be documented and tracked via this system. There should be regular reports generated to ensure actions are being completed appropriately and in a timely manner.	The Assistant Director of Nursing will confirm this requirement with all Divisions and a process of audit will be introduced, led by the Corporate PTR Team, for assurance.	31/10/2021	N/A	N/A	Complete	**6**	#VALUE!		The Health Board implemented a new system (RLDatix) for recording and managing complaints on 1 October 2021.This required training and education for users. Go live is June 2022.	07/05/2022	25/03/2022
2021.02	Internal	Putting Things Rights	Reasonable	Director of Nursing	Assistant Director of Nursing	Medium	R2 Upon the introduction of the Once for Wales concerns management system, all complaint actions should be documented and tracked via this system. There should be regular reports generated to ensure actions are being completed appropriately and in a timely manner.	The functionality of the new Datix system will be confirmed for all Divisions prior to implementation, together with the expectation that reports generated from Datix will be formally discussed in Divisional QPS meetings to monitor performance and learning.	31/12/2021	N/A	N/A	Complete	**4**	#VALUE!		Positive meeting with NCCU - action addressed.	07/05/2022	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R1 Clarity should be sought over the rolesandresponsibilities of each party and a governance process established within Radiology that ensures the easy flow of work requests across team boundaries.	We have had a recent upgrade and the boundaries were clearer. The SLA sits with I.T and Radiology are the application owner.ABUHB Radiologyinternallyrequest on service point if the department knows the server team need to undertake work. We will continue to do this.				Complete					07/05/2022	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R6 a.Radiology have requested CWS to work with WCP for fully electronic requesting. b.Staff have SOP's and checks when putting forms on however human errors do occur without fully electronic requesting.	Since this audit,this has now been altered and note it wasonlyone user with this many attempts all Administrators now have5attempts.				Complete					07/05/2022	25/03/2022
2021.07	Internal	Occupational Health	Substantial	Director of Workforce & OD	Director of Workforce & OD	Low	R1 The Health Board should:a)Remind clinical staff of the need to promptly update the administration section of a patient's file.b)Consider the value and benefit derived from using the administration section versus the effort required to maintain the latest position.	a.Issue included on the agenda(item 11a) of the Occupational Health Senior Clinical and Administration team meeting held on the 20thOctober 2021.b.All membersof the occupational health team involved in the process have been communicated with on the 8thNovember 2021to improve management of this data set.c.A monthly report query will be introduced from the 1stDecember 2021 to capture any outstanding issues as an additional assurance layer.	31/12/2021	N/A	N/A	Complete	**4**	#VALUE!		**April 2022** a.Issue included on the agenda(item 11a) of the Occupational Health Senior Clinical and Administration team meeting held on the 20thOctober 2021.b.All membersof the occupational health team involved in the process have been communicated with on the 8thNovember 2021to improve management of this data set.c.A monthly report query will be introduced from the 1stDecember 2021 to capture any outstanding issues as an additional assurance layer.	07/05/2022	25/03/2022
2021.10	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director, in consultation with external Project Manager	Medium	R1 The Project Execution Plan should be updated to reflect the current stage of the project / programme.	Agreed. Will liaise with the external Project Manager to issue an updated version.	31/12/2021	N/A	N/A	Complete	**4**	#VALUE!		The PEP was updated at the commencement of construction	07/05/2022	25/03/2022
2021.10	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	Low	R2 To enhance current arrangements, the terms of reference for the Project Team and Project Board should be reviewed and updated accordingly to include: • Coverage of frequency of meetings; • Quoracy for decision making; • Requirement for delegated deputies to be in attendance when there are periods of absence; and • The correct membership (named as generic roles / departments) reflective of both the project named management and current stage of the project.	Agreed. The terms of reference are currently being reviewed and updated for the recommended points including reference to the current stage of the project and the expectations of ownership by the members of the Project Team / Project Board.	30/11/2021	N/A	N/A	Complete	**5**	#VALUE!		The Terms of Reference of both have been updated	07/05/2022	25/03/2022
2021.10	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director, in consultation with the Cost Adviser.	Medium	R3 The Cost Adviser reports should be updated to incorporate a summary cumulative position to better visualise the current financial position of the project	Agreed. Whilst there is additional information available to the project team to understand the current financial position, it would be helpful to have the 'snapshot' in the Cost Adviser report. Will liaise with the Cost Adviser to include within the reports.	31/12/2021	N/A	N/A	Complete	**4**	#VALUE!		This is being provided	07/05/2022	25/03/2022
2021.10	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	Medium	R4 Welsh Government dashboard returns should be shared with an appropriate forum.	Agreed. The latest dashboard was shared with Project Board on 19 October 2021.				Complete					07/05/2022	25/03/2022
2021.10	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	High	R6 Recognising that main construction works have commenced on site, Confirmation Notice 2 should be executed as soon as possible.	Agreed. Both recommendations are being addressed as a matter of urgency.	30/11/2021	N/A	N/A	Complete	**5**	#VALUE!			07/05/2022	25/03/2022
2021.10	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	Medium	R7 Agreed. Both recommendations are being addressed as a matter of urgency.	Agreed. Discussions will be held with all relevant parties to confirm the delay damages calculation, and agreed amount, to be included in Confirmation Notice 2.	30/11/2021	N/A	N/A	Complete	**5**	#VALUE!			07/05/2022	25/03/2022
2021.10	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	High	R8 Noting that no action can be taken at this project, management should ensure that the requirements of the NHS Wales Investment Infrastructure Guidance are applied at all future projects with regard to Enabling Works and Advanced Works.	Agreed. NHS Wales Investment Infrastructure Guidance will be followed on all future projects.	Noted for future projects	N/A	N/A	Complete	**#VALUE!**	#VALUE!		No Action required , noted for future projects	07/05/2022	25/03/2022
2021.10	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	High	R9 The Project Director should advise the UHB Board of the actions taken to award the Enabling Works element of the contract and the non-compliance with the NHS Wales Investment Infrastructure Guidance.	Agreed. The issue was raised at Project Board and will be raised / discussed further in the first instance at the Strategic Capital and Estates Workstream. It should be noted that the demolition process was conducted via a separate contract and the provision of compensation event for the subsequent grouting was, and is considered, to be the correct approach. It is accepted that the Advance Works should have had a separate contract.	30/11/2021	N/A	N/A	Complete	**5**	#VALUE!		No Action required , noted for future projects	07/05/2022	25/03/2022
2021.10	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	Medium	R10 Post submission of KPIs, the Project Board should discuss the collective output [and trend of previous submissions] to ensure issues with performance are reviewed and addressed in an appropriate and timely manner.	Agreed. Collective discussions are now being held for the returns on all current projects. It would be preferred if these discussions were held prior to submission of returns to NWSSP:SES, but it is acknowledged this is not the expectation for collation of DfL data	31/12/2021	N/A	N/A	Complete	**4**	#VALUE!		Overtaken by events, Shared Services do not want collective discussion on KPIs	07/05/2022	25/03/2022
2021.10	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	Medium	R11 The risk register should be reviewed to incorporate applicable costs; with the costs regularly reviewed to facilitate monitoring of the project.	Agreed. The initial project risk register informed the FBC contingency pot [September 2020]. Work is underway to complete a reconciliation for the current financial position to review how much of the contingency sum will be consumed with the correct projected overspend for the project. This will then be further analysed to cost the risks, as applicable, on a line-by-line basis.	31/12/2021	N/A	N/A	Complete	**4**	#VALUE!		Risk Registers are reviewed on a quarterly basis	07/05/2022	25/03/2022
2021.10	Internal	Tredegar Health & Wellbeing Centre	Reasonable	Director of Planning, Digital & IT	Strategic Capital & Estates Director	Low	R12 The risk register should be updated to reflect the current risk regarding the financial position of the project, and the proposed mitigating actions / countermeasures.	Agreed. This risk, and any other new ones identified, will be included in the next risk register review scheduled with the external Project Manager.	30/11/2021	N/A	N/A	Complete	**5**	#VALUE!		Risk Registers are reviewed on a quarterly basis	07/05/2022	25/03/2022
2021.09	Internal	GUH: Technical Assurance	Substantial	Director of Planning, Digital & IT	Estates Manager	Low	Management should ensure the ability to utilise "as fitted" water configuration diagrams (e.g. via rights to utilise third party software, or procured software).	Agreed. A capital bid has been submitted by the division to (a) employ full time CAD staff to keep records up to date and (b) to have access to the third-party software.	31/03/2022	N/A	N/A	Complete	**1**	#VALUE!		Noted for future procurement	07/05/2022	25/03/2022
	Internal	Hospital Sterilisation and Disinfection Unit (HSDU) Project (2020/21)	Reasonable	Director of Planning, Performance, Digital & IT	Strategic Capital & Estates Programme Director	Medium	R1 The UHB should have appropriate procedures in place to ensure that when determining the preferred supplier to inform the design, confirmation is received of willingness to participate in the subsequent procurement/market testingexercise (O).	Agreed. It is not completely clear what exactly went wrong with the procurement process and why it took so long to select a preferred supplier. The lessons learnt exercise will attempt to address both issues.	31/05/2021	N/A	N/A	Complete	**11**	#VALUE!		No action required noted for future projects	07/05/2022	
	Internal	Hospital Sterilisation and Disinfection Unit (HSDU) Project (2020/21)	Reasonable	Director of Planning, Performance, Digital & IT	Strategic Capital & Estates Programme Director	Medium	R2 Lessons learnt from the development of the design and equipment procurement exercise should be captured, either separately or as part of the formal post project evaluation (O).	Agreed. It is not completely clear what exactly went wrong with the procurement process and why it took so long to select a preferred supplier. The lessons learnt exercise will attempt to address both issues.	31/05/2021	N/A	N/A	Complete	**11**	#VALUE!		Lessons Learnt report has been issued for comment	07/05/2022	
	Internal	Hospital Sterilisation and Disinfection Unit (HSDU) Project (2020/21)	Reasonable	Director of Planning, Performance, Digital & IT	Strategic Capital & Estates Programme Director	Medium	R3 For accuracy of reporting, the Cost Adviser cash-flows should be reconciled to UHB payments made. (O)	Agreed; and has already been addressed.	N/A	N/A	N/A	Complete	**#VALUE!**	#VALUE!			07/05/2022	
	Internal	Hospital Sterilisation and Disinfection Unit (HSDU) Project (2020/21)	Reasonable	Director of Planning, Performance, Digital & IT	Strategic Capital & Estates Programme Director	Medium	R5 The monthly Welsh Government dashboard reports should be submitted in accordance with expectation (O).	Agreed. The Welsh Government reports will continue to be submitted.	31/03/2021	N/A	N/A	Complete	**13**	#VALUE!		The project has now been completed	07/05/2022	
	Internal	Hospital Sterilisation and Disinfection Unit (HSDU) Project (2020/21)	Reasonable	Director of Planning, Performance, Digital & IT	Strategic Capital & Estates Programme Director	Medium	R6 An HDSU Project Board should be established to take through to completion / handover (as a minimum) (O)	Agreed. The GUH Project Board currently fulfils this function and alternative arrangements will be made after the April 2021 meeting.	30/04/2021	N/A	N/A	Complete	**12**	#VALUE!		The LGH Reconfiguration Board has fulfilled the role of Project Board and prior to that it was undertaken by the GUH Project Board	07/05/2022	
	Internal	Hospital Sterilisation and Disinfection Unit (HSDU) Project (2020/21)	Reasonable	Director of Planning, Performance, Digital & IT	Strategic Capital & Estates Programme Director	Medium	R7 At future projects:Contract documentation should be signed in a timely manner, prior to the commencement of works.	Agreed. The importance of a quick turnaround of contract documents has been relayed to the various project SCPs, PMs and ABUHB corporate services.	31/03/2023	N/A	N/A	Complete	**-11**	#VALUE!		Noted for future projects	07/05/2022	
	Internal	Clinical Audit Follow-up (2018/19)	Limited	Medical Director		High	R3 The Clinical Audit Policy states that the Divisional Directors"are responsible for maintaining the overview of local clinical audits within the Directorates, to ensure they complywith the Policy". However, there is no mechanism for holding the divisions to account in this process. We have set out our recommendations to ensure appropriate accountability in the divisional clinical audit process below.3.1The divisions should produce anannual workplan of assurance against their major clinical risks, including, but not limited to, clinical audit.3.2The divisions should provide a clinicalassurance report to each QPSOG meeting, detailing the assurance work undertaken against the annual workplan. The reports should also highlight any significant issues arising from the assurance workand detail the action being taken to address these issues.3.3A high level summary of the clinical	3.1-3.3.Whilst the Divisions willproduce andpresent annual workplans of assurance against their major clinical risks, and significant issues arising from the work plan,alignment of these risks to clinical audit for improvement will be highlighted within the work plans.These will be presented to the CESG, and this will be summarised in an annual over view of Clinical audit to QPSC every Septemberfrom 2020.3.4 The clinical audit registration form and checklist will be updated and be available on the Clinical Audit intranet site.	31/03/2020	N/A	N/A	Complete	**25**	#VALUE!		ABUHB has procured of a digital clincal audit platform AMaT that will support the registration, completion, reporting of all clinical audits and the development and monitoring of improvement plans. The revision of the Clinical Audit Strategy and Policy will support the development of Divisional audit plans over the course of 2022	07/05/2022	
2021.12	Internal	Risk Management	Reasonable	Board Secretary	Head of Risk	Medium	R1.1 The Health Board should: • Develop a plan setting out how key objectives within the Risk Strategy will be achieved, with milestones set out. The progress of the plan should be reported into the Audit, Finance and Risk Committee. • Review the Risk Strategy to determine if it still reflects current practice and update it accordingly e.g. the corporate overview or risks.	A plan has been developed and is being presented to the Audit Committee on 7th April 2022 following discussion with Executive Team. A review of the Strategy will be undertaken as part of the plan, in September 2022, specifically to review effectiveness one year post implementation.	30/09/2022	N/A	N/A	Complete	**-5**	#VALUE!		Risk Strategy Realisation Plan agreed. Routine updates scheduled within ARA Committee workplan for 2022/23	07/05/2022	07/04/2022
2021.13	Internal	Continuing Healthcare MH&LD	Limited	Director of Nursing/Director of PCCMH		High	3.1 a. The Health Board should explore options for strengthening its oversight of services commissioned, on its behalf, through the NCCU, with reporting to the PQSOC. b. The Health Board should request the NCCU informs commissioners when providers do not re-join the AWF.	a. This Audit recommendation will be discussed with the NCCU to explore opportunities for strengthening monitoring and ABUHB oversight. b. The NCCU will be asked to inform ABUHB when a provider does not re-join the AWP list.	30/04/2022	N/A	N/A	Complete	**0**	#VALUE!			07/05/2022	07/04/2022

ABUHB	Audit Type	Report Title	Assurance	Director	Responsible	Ref / Priority	Recommendation	Management Response	Agreed	Revised	Revised	Due	No. of	No. of months past	If closed	Progress being made to implement recommendation				Reporting Date	Date Added to
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	High	R3 Whilst we understand the Health Board is in the process of planning to upgrade to the 2016 version we highly recommend that the Health Board expeditesthe upgrade.	This upgrade took place on 14thNovember however only application server was upgraded. DHCW and ABUHB are working closely to plan the rest of the upgrade. However DHCW will not touch the RadIS local database which stores all of our crystal reports and letters. This is a risk and we havegone to our server team internally to plan anbackupsolutionfor the RadIS local database.	30/04/2022	N/A	N/A	Not yet due	0	#VALUE!						07/05/2022	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R7 The success of the use of the leavers list should be monitored to ensure that it works as anticipated and that all leaver accounts are removed on a timely basis.	We monitor this as much possible in Radiology. We have recently started receiving consultant leaver'slists from the Health Board and action these also.The success of the process will be tracked and evaluated to ensure it is working.	30/04/2022	N/A	N/A	Not yet due	0	#VALUE!						07/05/2022	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R9 A formal disaster recovery plan for WRIS should be developed.	The Disaster recovery plan is to fail over to a mirrored system however, since the upgrade this needs to be re-visited and formally set out. ABUHB have a VMware environment where this is hosted.The Radiology departments have disaster recovery by using emergency packs in each department and a policy that explains how to use these emergency packs in a Radis downtime scenario.	30/04/2022	N/A	N/A	Not yet due	0	#VALUE!						07/05/2022	25/03/2022
2021.12	Internal	IT System Controls (WRIS)	Reasonable	Director of Operations	PACS & RADIS Manager	Medium	R10 The WRIS backups should be subject to regular testing / restore to ensurevalidity.	A request to ensure that a process for regular testing of the back up to ensure	30/04/2022	N/A	N/A	Not yet due	0	#VALUE!						07/05/2022	25/03/2022
2021.05	Internal	Pathology	Reasonable	Director of Operations	Pathology Governance Manager	Low	R2 b Periodic trend analysis / pattern identification should be completed across all instances of non-conformanceand used to identify common areas of concern for corrective/preventiveaction.	.Try to identify themes and trends across Pathology, though inspections are held at different times of the year for each discipline so not as straightforward.	TBC	N/A	N/A	Not yet due	#VALUE!	#VALUE!						07/05/2022	25/03/2022
202101	External	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Workforce & OD		High	The Health Board should review the arrangements in place toensure that annual leave for all staff is accurately recorded and held centrally	The introduction of Medical E-Systems will ensure that all leave is recorded. The Health Board have agreed to procure a suite of Medical E-Systems with roll out in April 2022. However, departments have started recording leave in Electronic Staff Record (ESR). Communications will be sent to Medical Leaders in December 2021 to ensure that leave is recorded onto ESR pending the introduction of full Medical E-Systems.	30/04/2022	N/A	N/A	Not yet due	0	#VALUE!		April 2022 the roll out the newly procured workforce medical e-system will resolve the logging of annual leave centrally	Given current pressures on staff it is not felt that a interim system change of 12 months would be beneficial			07/05/2022	25/03/2022
202101	External	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Finance, Procurement & Value		Low	The new asset tagging system should be implemented as soon as possible, and in readiness for the audit of the 2021-22 financial statements.	The interface between the Fixed Asset Register (Asset 4000) and the new RFID system is complete. The team are working through final issues identified on the user testing of the interface between the EBME equipment register and the RFID system during November 2021, with a view to going live with the system by the end of the month. The user training sessions have taken place. The tagging of new and existing equipment assets has commenced with around 1400 assets tagged to date. The programme of tagging of existing assets will run into the 2022/23 financial year due to the volume of assets and current capacity of staff. However, the finance team are progressing a fixed term appointment to support the delivery of this work over the next year.	31/03/2023	N/A	N/A	Not yet due	-11	#VALUE!						07/05/2022	25/03/2022
202103	External	Audit of Accounts Report – ABUHB Charitable Fund and Other Related Charities (Dec 2021)	Not Rated	Director of Finance, Procurement & Value		Medium	FCPs not being updated to reflect the changing profile of the investment portfolio. In addition, the Charitable Fund should consider having clearer procedures regarding the classification of income.	The Charitable Funds financial control procedure is reviewed on a 3-year rolling basis and is due for review in July 2022. Going forward, additional reviews will be carried out on an annual basis to ensure that the procedure remains relevant and that no significant changes have occurred since the last review.For clarity, the income section (section 9 of the current financial control procedure) will be enhanced to include a more detailed section on the types of income received by the Charity and how the classification is determined, eg grant, donation, legacy etc. and the documentation required to be obtained/retained to verify this classification.	31/07/2022	N/A	N/A	Not yet due	-3	#VALUE!						07/05/2022	25/03/2022
202104	External	Taking Care of the Carers (Oct 2021)	Not Rated	Director of Workforce & OD		Not rated	R6 NHS bodies should seek to build on existing local and national workforce engagement arrangements to ensure staff have continued opportunities to highlight their needs and share their views, particularly on issues relating to recovering, restarting, and resetting services. NHS bodies should ensure these arrangements support meaningful engagement with underrepresented staff groups, such as ethnic minority staff.	The Health Board has initiated an innovative 12-month engagement programme called "#PeopleFirst, #CynnalCynefin, reconnecting our workforce". The origins are within the values of the Health Board and is a collaborative programme delivered by Wellbeing, OD and the Executive Board. The programme aims to re-connect staff to each other, to managers and senior leaders to empower them to raise and solve local problems locally, raise concerns to a higher level and offer the experience of feeling heard. As of December 2021, the project team have run 6 hospital site-based events, interacted with over 50 staff who have raised over 90 issues which we are working on. The project continues into the new year with cross-executive support.	31/12/2022	N/A	N/A	Not yet due	-8	#VALUE!		**April 2022** The project team have concluded phase 1 and 2 of the project. Phase 1 was establishing key comms methods. Phase 2 was hosting executives and General managers of site to connect with staff to understand their issues and needs to improve their experience of work. 26 session were completed, speaking with over 250 staff, raising 143 issues of which 75% have an answer.	Phases 1 and 2 have been presented widely across the organisation including the Board, Execs, TUs and professional leads. Phase 3 will include a continued informal extention of phase 2 (until september 2022) and also working with divisional triumvirates to understand and design engagement methods for their teams.	Phase 3 will commense within May 2022.		07/05/2022	25/03/2022
202105	External	Structured Assessment 2021	Not Rated	Director of Planning, Performance, Digital & IT	Associate Director of Communications and Engagement	Not rated	R1 The Health Board's website contains some outdated information relating to its governance arrangements and incomplete performance data which is not supported by appropriate explanatory information. The Health Board, therefore, should take immediate action to ensure: • Content is well organised, easy to navigate, clear and concise, and • Key information / data is up-to-date and in a format that the public and stakeholders can interpret and	The Health Board accepts this recommendation. The website is in the process of being reviewed and updated to reflect suggestions made including, ensuring all fundamental Health Board information (related to Board, Committees, and governance arrangements) is accurate and up to date for the public and stakeholders. Further developmental work will be required to ensure Divisional engagement around local pages on the website are kept up to date with useful and meaningful information. However, it should be acknowledged that the resource required in order to conduct such a substantial	31/03/2023	N/A	N/A	Not yet due	-11	#VALUE!						07/05/2022	25/03/2022
202105	External	Structured Assessment 2021	Not Rated			High	R5 The Health Board has not finalised its monitoring framework due to the pandemic, subsequently there continues to be limited oversight and scrutiny at Board-level on overall delivery against priorities outlined in the 2021/22 Annual Plan. The Health Board, therefore, should complete the development of its monitoring framework as soon as possible to allow the Board to review and if necessary, challenge delivery of its strategic priorities and progress against the Annual Plan and future Integrated Medium-Term Plans.	The Health Board accepts this recommendation. The delivery framework of the 3 year IMTP process did include a quarterly monitoring report structure which has not been completed this year against the annual plan due to the challenges of the Health Board's response to the pandemic and other priorities. The shared objective of developing a comprehensive outcomes based framework for the organisation is a developmental one and progress has been limited in this area due to the challenges associated with the pandemic, a change in leadership of the performance function (due to the Exec team changes referenced in the report) and due to Welsh Government developing an All Wales outcomes framework that would enable the Health Board to align a local framework to. The Health Board will therefore develop the first iteration of	30/06/2022	N/A	N/A	Not yet due	-2	#VALUE!						07/05/2022	25/03/2022
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Planning, Performance, Digital & IT		N/A	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.	31/12/2022	N/A	N/A	Not yet due	-8	#VALUE!		November 2021 Update: This is pending the TOF being funded and requires a full risk assessment to be conducted once the business analysis has been completed.				07/05/2022	
2021.16	Internal	Flu Immunisation	Reasonable	Director of Public Health and Strategic Partnerships	Consultatnt in Public Health	Medium	R1 a.The Health Board should review and investigate all promotional activity and flu vaccination delivery methods to determine the degree of success each brings. Alongsidethis, a reflection exercise should be completed to identify any lessons to be learnt or improvements to incorporate in future campaigns R1 b.Theflu champion database should be reviewed, updated and regularly maintained.	a.The Health Board will be holding annual Staff Flu Vaccine planning event for 2022-23 in April/May 2022. This report will be shared with the Staff Flu Working Group in advance to ensure that members have the opportunity to reflect on this report. This event will both reflect and act on the lessons learnt during the provision of staff vaccines during 2021/22,from an operational, communication and organisational view,as well as providing analysis of all available division/flu champion/vaccination data. Lessons learnt will be highlighted during this event and 2022/23 will be planned strategically to take advantage of positiveaspects, such as the mass vaccination centre approach (if an option), improving the flu champion model through improved digital innovation/organisational planning as well as mitigating barriers to vaccine uptake born of the staff survey/reflections.It is intended to be supported by a staff survey of "how they felt the vaccine programme did." It will form the basis of a user centred approach by listening to employee concerns as well as an opportunity to capture staff ideas.In addition,itis anticipated that greater use of technology	31/07/2022	N/A	N/A	Not yet due	-3	#VALUE!						07/05/2022	07/04/2022
2021.16	Internal	Flu Immunisation	Reasonable	Director of Public Health and Strategic Partnerships	Consultatnt in Public Health	Low	R2 a. The terms of reference for both Working Groups should be reviewed and updated where required. R2 b. The terms of reference for each group should be finalised.	a.Staff Flu Immunisation Working Group will review and update the Terms of Reference at the planning event b.Staff Flu Immunisation Working Group Terms of Reference will be finalised once reviewed.c.Community Flu Immunisation Working Group Terms of Reference will be reviewed and finalised.	31/07/2022	N/A	N/A	Not yet due	-3	#VALUE!						07/05/2022	07/04/2022
2021.15	Internal	Falls Management	Reasonable	Director of Therapies & Health Science		High	R1 a.Identify any underlying reason for the non-completion of MFRAsand the impact of the pandemic.	a.It is recognised that the non-completion of the falls risk assessment is multifactorial and the challenges have been heightened during the Covid pandemic. This is both in association with the changing levels of comorbidities for our patient cohort and the availability of staff resources due to competing demands in support of the Health Boards response to the pandemic.Some wards were also subject to changes in their functions with the redistribution of patients in support of the management of the pandemic. The Health Board through its falls management structure will continue to utilise both qualitative and quantitative information to identify themes and trends to instigate the necessary quality improvement initiatives. This will look to include a broader remit of evaluating compliancewith the completion of the MFRAthrough the development of an audit suite aligned to and extending the existing methods being adopted by the wards. The outcomes will look to define any change requirements and will be communicated at all levels within the organisationstructures.	31/07/2022	N/A	N/A	Not yet due	-3	#VALUE!						07/05/2022	07/04/2022
2021.15	Internal	Falls Management	Reasonable	Director of Therapies & Health Science	AD of Therapies & Health Sciences		R1 b.Review the MFRA documentation to determine if it can be rationalised / updated to be more concise. For example, a permanent section and an ongoing care plan that is periodically revised.	b.The MFRA represents one assessment within the suite of the Welsh National Care Records (WNCR). This is due to be adopted in its intended electronic format in ABUHB in the Summer of 2022and will provide a more streamlined systematic MFRA. Although currently being used in a paper format ABUHB as part of the process have submitted a number of change requests,which have been accepted. The detail held within the MFRA is reflective of the many factors which influence the risks of falls and likewise contribute to the wider understanding of the patient's condition. ABUHB is represented at National level and will continue to contribute to the discussions.	30/09/2022	N/A	N/A	Not yet due	-5	#VALUE!						07/05/2022	07/04/2022
2021.15	Internal	Falls Management	Reasonable	Director of Therapies & Health Science	AD of Therapies & Health Sciences		R1 c.Continue with the falls management training, but target the programme towards areas of poorer compliance rates.	c.It is recognised that training is a key component in supporting the ABUHB's approach in minimising inpatientfalls. The aim is to build on what has already been established. The evaluation of data willlook to underpin a focussed approach where areas of concern are identified and will look to inform the training strategy going forward. Aligned to the work of ABUHB we are also representedat an 'All Wales's levelin discussions to develop a generic learning platform linked to ESR to support all staff who have a role infalls management. It is intended that this will translate into a national product and provided consistency of approach across Wales.This platform will support enhancing knowledge and skills from both an inpatient and community perspective. The learning package will provide a level 1-2 education upon which additional modules will be developed.	31/12/2022	N/A	N/A	Not yet due	-8	#VALUE!						07/05/2022	07/04/2022
2021.15	Internal	Falls Management	Reasonable	Director of Therapies & Health Science	AD of Therapies & Health Sciences		R1 d. Remind staff of the falls management requirements.	d.Through the newly established structure in support of falls management an ongoing awareness campaign is to be established. The further development of theintranet pages through SharePoint willthe provideenhancedcommunication approaches. This will be looked at in the context of falls from a Hospital and Community perspective.This will be used to develop a falls network, provide a platform to share good practice, research and act as a resource depository.The concept of falls champions will be promoted. All will look to support quality improvement initiatives across the falls pathways. The agendas set for the fall'sforums will look to ensure suchgood practice, learning and necessary change initiatives continue to promote the requirements to manage falls.	30/09/2022	N/A	N/A	Not yet due	-5	#VALUE!						07/05/2022	07/04/2022
2021.15	Internal	Falls Management	Reasonable	Director of Therapies & Health Science	AD of Therapies & Health Sciences		R1 e.Where 1P1D/DECi inspections identify failures an immediate correction of the patient record and a rerun of the check (and potentially training) should be completed.	e.Should non-compliance concerns be identified the findings are shared with the Nurse in Charge, Ward Manager along with the Senior Nurse and QPS Lead. The outcomes are relayed to the member of staff responsible for the care of the patient and the wider team as a means of learning.The responsible member of staff looks to action any requirements to rectify non-compliance. The QPS Lead subsequently undertakes a more extensive focussed audit to identify any systemic concerns within the given ward and to inform the Divisional 'deep dive' discussions. Work is underway to look at how the data can be cross referenced with the overarching falls management data and on the reinstatement of the Health and Care Standards Audits. This approach will look to be supported by the training strategy.	31/12/2022	N/A	N/A	Not yet due	-8	#VALUE!						07/05/2022	07/04/2022
2021.15	Internal	Falls Management	Reasonable	Director of Therapies & Health Science	AD of Therapies & Health Sciences	Medium	R2. The falls investigation and Datix recording process should reference the MFRA and confirm its completion in relation to the fall event. A fall should not be identified as 'unexpected' if a MFRA had not been completed, when it should have been (e.g. over the age of 65 years).	An ongoing audit process will be established aligned to evaluating the completion of DATIX incidents and the associated completion of the MFRA and will be included as an element of an audit cycle Due consideration will need to be given to the format of the incident reporting criteria within the new system.	30/09/2022	N/A	N/A	Not yet due	-5	#VALUE!						07/05/2022	07/04/2022
2021.14	Internal	GUH: Quality Assurance	Reasonable	Director of Planning, Performance, Digital & IT		Medium	R1.1 Management should confirm available data and conclusions relating to functionality of the GUH, by comparison to business case objectives pre and post opening.	Agreed	TBC	N/A	N/A	Not yet due	#VALUE!	#VALUE!						07/05/2022	07/04/2022
2021.14	Internal	GUH: Quality Assurance	Reasonable	Director of Planning, Performance, Digital & IT		Medium	R1.2 Management should re-baseline relevant, objectives for the facility based on current information in order to inform revised functional	Agreed	TBC	N/A	N/A	Not yet due	#VALUE!	#VALUE!						07/05/2022	07/04/2022
2021.14	Internal	GUH: Quality Assurance	Reasonable	Director of Planning, Performance, Digital & IT		Medium	R2.1 Management should confirm an appropriate forum to which to report on-going monitoring of the investment benefits derived from the GUH facility.	Agreed. The reporting of the energy efficiency benefits of GUH will be picked up as part of the broader energy review and discussed at the Strategic Capital & Estates Group.	TBC	N/A	N/A	Not yet due	#VALUE!	#VALUE!						07/05/2022	07/04/2022
2021.12	Internal	Risk Management	Reasonable	Board Secretary	Head of Risk	Medium	R2.1 The Health Board should: • Consider undertaking risk management training for key areas, whilst awaiting the implementation of the risk management module within DatixCloudIQ. • Develop a plan to deploy risk management training, to commence once the full implementation of DatixCloudIQ has been completed.	As part of the strategy realisation plan, the Health Board will develop an in-house training package aimed at the three levels outlined within the Strategy (operational, management and Board level). This will be made available to relevant staff during May/June 2022. Further National development work will resume once the RLDatix risk management module has been finalised and bespoke training programmes can then be developed.	30/06/2022	N/A	N/A	Not yet due	-2	#VALUE!						07/05/2022	07/04/2022
2021.12	Internal	Risk Management	Reasonable	Board Secretary	Head of Risk	Medium	R3.1 The Health Board should: • Provide guidance detailing how risks should be recorded and monitored at different levels within the organisation. • Ensure each risk entry is fully recorded in a standard format.	3.1 This recommendation forms part of the Risk Management Strategy realisation plan. The Health Board training programme will provide material and literature to help support staff to populate Datix and risk registers appropriately and consistently ensuring alignment with best practice. The provision of in-house training will be made available to staff by May/June 2022.	30/06/2022	N/A	N/A	Not yet due	-2	#VALUE!						07/05/2022	07/04/2022
2021.13	Internal	Continuing Healthcare MH&LD	Limited	Director of Primary, Community Care and Mental Health	Divisional Nurse/Divisional Director	High	R 1.1 The Division should further strengthen performance reporting, with a heightened focus on QPS metrics (akin to the processes embedded with the Complex Care Division: general adults). 1.2 The Division should explore interim options to automate and streamline the existing databases until the introduction of WCCIS, and ensure the databases are up to date. 1.3 The Division should improve the reporting arrangements of commissioned services ensuring Executive sightedness together with Patient Quality, Safety & Outcomes Committee. 1.4 The Divisional Risk Register should be updated to include the risk associated with the	1.1 The Performance report will be strengthened to include PQS metrics. 1.2 The utilisation of the databases will be reviewed with an interim plan developed to reduce duplication and ensure completeness. 1.3 A quarterly performance report will be produced and discussed at Divisional level and the Executive Assurance meeting, together with inclusion in the PQSOC Performance Report as per the business cycle.1.4 The Divisional Risk register will be updated to include the risks associated with the auditing backlog.	30/06/2022	N/A	N/A	Not yet due	-2	#VALUE!						07/05/2022	07/04/2022
2021.13	Internal	Continuing Healthcare MH&LD	Limited	Director of Primary, Community Care and Mental Health	Divisional Nurse/Divisional Director	High	4.1 Divisional management should ensure: a. the Division introduces a sustainable programme of training for CHC; and b. CHC compliance and quality audits are incorporated into the Divisional clinical audit plan.	a. A business plan inclusive of the training requirements for Commissioning is being considered by the Divisional Management Team in conjunction with other IMTP priorities. The CHC framework forms part of the training needs identified. A bid for temporary funding for training personnel will be prepared to address this issue quickly. b. Clinical auditing of the CHC process will be added to the annual Divisional audit plan.	30/06/2022	N/A	N/A	Not yet due	-2	#VALUE!						07/05/2022	07/04/2022
2021.13	Internal	Continuing Healthcare MH&LD	Limited	Director of Primary, Community Care and Mental Health	Divisional Nurse	High	R5.1 A revised framework, following the launch of the new national CHC policy (anticipated April 2022), should include client-specific requirements for MH & LD and ensure consistent use across all Health Board services.	5.1 The Deputy Divisional Nurse for MH/LD will work closely with the Divisional Nurse for Complex Care to ensure inclusion of MH/LD client specific requirements within the revised framework for CHC, following the launch of the new national policy.	30/06/2022	N/A	N/A	Not yet due	-2	#VALUE!						07/05/2022	07/04/2022
2021.13	Internal	Continuing Healthcare MH&LD	Limited	Director of Primary, Community Care and Mental Health	Divisional Nurse/Finance Business Partner	Medium	R6.1 The Division should: a. undertake a review of its overarching CHC / S117 provider contracts, ensuring they include all aspects of performance monitoring; b. identify appropriate signatories for the contracts in line with the Standing Orders and Scheme of Delegation.	6.1 a. A Task and Finish Group will be convened to review and strengthen the contracts. b. The authorised signatories list will be reviewed to ensure full compliance with the Scheme of Delegation and Standing Orders.	31/07/2022	N/A	N/A	Not yet due	-3	#VALUE!						07/05/2022	07/04/2022
2021.17	Internal	Corporate Governance: BAF	Reasonable	Board Secretary	Head of Risk	Medium	We recommend that the Health Board assesses the effectiveness of those assurances on which reliance is being placed, and report their findingsor gaps identifiedas part of the BAF reporting structure.Where gaps are identified action plans should be developed and monitoredfor progress.	R1. The Health Board accepts this recommendation as part of the iterative development of the Board Assurance Framework. Work to address this recommendation is planned during May/June 2022 and a revised BAF incorporating a robust assessment of assurances will be included. Assurances will be RAG rated and identified gaps will have associated plans to improve the position, monitored by the Audit,Risk and Assurance Committee.	31/07/2022	N/A	N/A	Not yet due	-3	#VALUE!						07/05/2022	30/06/2022
2021.17	Internal	Corporate Governance: BAF	Reasonable	Board Secretary	Head of Risk	Medium	R4. We recommend that the Health Boarddevelops a periodic report commenting on compliance/ the effectiveness of the BAFprocessand reports this to an appropriate committee.	The Health Board accepts this recommendation and will incorporate a review of the effectiveness of the BAF into Board evaluation and committee self assessment processes.	30/04/2023	N/A	N/A	Not yet due	-12	#VALUE!						07/05/2022	30/06/2022
2021.17	Internal	Corporate Governance: BAF	Reasonable	Board Secretary	Head of Risk	Low	R2. We recommend that the Health Board completes an assurance mapping exercise to record all assurances being sought in relation to those principalrisks reported under the BAF process. The exercise should be regularly reviewed to identify any missing and / or the accuracy of theassurance.	The Health Board accepts this recommendation and actions to undertake this are outlined in recommendation 1. The Health Board has established processes in place to review the BAF at least twice yearly with all principal risks reported to executive team, relevant committees and to the Board at each meeting.	31/07/2022	N/A	N/A	Not yet due	-3	#VALUE!						07/05/2022	30/06/2022
2021.17	Internal	Corporate Governance: BAF	Reasonable	Board Secretary	Head of Risk	Low	R3. We recommend that the Health Board continues to monitor the embedding of the BAF related risk management oversight responsibilities of the Committees to ensure that:1 the Committee Risk papers form the basis of the six monthly BAF reporting to the Audit, Risk and Assurance Committee and the Board; and,2 appropriate oversight is provided by each Committee on reported BAF activity.	The Health Board accepts this recommendation and plans to include strengthened assurance mapping arrangements and assessments for the next iteration of the Board Assurance Framework (BAF). In addition to this, the template reporting for Board and Committees is due to be reviewed, it is proposed that incorporated into this review will be the ability to cross reference each Board and Committee report to the BAF to make explicitly clear where papers address and provide assurance against a principal risk.	31/07/2022	N/A	N/A	Not yet due	-3	#VALUE!						07/05/2022	30/06/2022
2021.18	Internal	Financial Sustainability	Reasonable	Director of Finance, Procurement & Value	Assistant Finance Director	Low	R1 The upcoming review of theBudgetary Control Policy and Financial Control Procedure, issue 3, should considerestablishing effective control procedures that allow for practical compliance across the Health Board and that any accepted deviation from defined procedures isdocumented, such that authorisation of such changes is defined and communicated. Areas for consideration include:1.1.1whetherthe formal budget delegation and acceptance letter process applied to the initial annual budget needsto be applied to any significantbudget changes madeduringthe financial year;1.1.2shouldthe monthly budget review and reporting processes reflect the specific needs of each division / directorate, given an assessment of the variation in budget risk between the divisions; and1.1.3whethereach virement requiresformal approval by the Board or could delegation of authority be given to the ExecutiveTeamwith the subsequent notification to the Board, subject toappropriatefinancial limits.The full findings of this review should be consideredwhen the documents are reviewed.	1.1.1Delegation of such large £'s during the year is relatively recent and became apparent during Covid due to late notice of confirmation and receipt of funding.We would normally expect to issue delegation letters only at the start of the financial year, whenthe vast majority of budgets are delegated, recognising that these are at a point in time, there will always be subsequent changes as new funding is agreed.The delegation is approved by the CEO and the expectations of managing that budget are clear in the initial letter and FCP's. The FCP will be reviewed and revised to reflect the clarity of this process. 1.1.2The Board financial report includes an overview of each budget head.'FBI' provides the standard ABUHB Budget holder reports in detail.No action proposed. 1.1.3The budget is delegated through the Board and CEO to the Executive, to deliver the agreed priorities. There should be no need to refer changes to the Board as they have already delegated the authority of its management. However, where there are significant changes to the proposed usage which are outside of agreed priorities and delegation arrangements, there is an expectation that the Board	31/08/2022	N/A	N/A	Not yet due	-4	#VALUE!						07/05/2022	30/06/2022
2021.18	Internal	Financial Sustainability	Reasonable	Director of Finance, Procurement & Value	Assistant Finance Director	Low	R2 The Directorof Finance, Procurement& Valueshouldensurethatthe budgetarycontroltraining provided is appropriate and that each staff member receives an adequate level oftraining toaddress their needs andfulfil their role.This should includetheinclusion of budgetary control training in staff PADRs (where appropriate),monitoring attendance at budgetary control training sessions,and clear, documented justification where a budget holder does not need to attend the training(for example, if they had significant budgetary control experience in a previous role).	Financial and budget training is part of induction training sessions and FBI training is provided in addition to encouraging budget holders to attend.Non attendance reports are provided to line managers and Business Partner Accountants teams to follow up.Reminders will be sent to all budget holders and line managers to ensure attendance	31/08/2022	N/A	N/A	Not yet due	-4	#VALUE!						07/05/2022	30/06/2022
2021.18	Internal	Financial Sustainability	Reasonable	Director of Finance, Procurement & Value	Assistant Finance Director	Low	R3.1 Going forward, the Director of Finance,Procurement& Valueshouldconsider enhancing/ expandingthe Board reporting around the delivery ofsavings plans, as pressure to deliver a sustainable balanced budget becomesever increasing.	Savings information is provided in summary in the Board Financial Report, in addition the appendix provides a line by line analysis.The Finance & Performance Committee will receive a more detailed savings analysis as part of regular agenda updates, including analysis of recurrent, non-recurrent and delivery performance.	31/07/2022	N/A	N/A	Not yet due	-3	#VALUE!						07/05/2022	30/06/2022
2021.18	Internal	Financial Sustainability	Reasonable	Director of Finance, Procurement & Value	Assistant Finance Director	Low	R3.2 Whilst savings are not separately budgeted for, the Director of Finance, Procurement & Values should consider the reporting of savings achieved analysed by key generic savings activities across the Health Board. For example,an analysis of savings planned and achieved fromthe more effective management of variable paycosts across the Health Board, orthe avoidance of additional costsas a result of efficiencies achieved.	Savings information is provided in summary in the Board Financial Report, in addition the appendix provides a line by line analysis.The Finance & Performance Committee will receive a more detailed savings analysis as part of regular agenda updates, including analysis of recurrent, non-recurrent and delivery performance.	31/07/2022	N/A	N/A	Not yet due	-3	#VALUE!						07/05/2022	30/06/2022
2021.18	Internal	Financial Sustainability	Reasonable	Director of Finance, Procurement & Value	Clinical Futures Programme Director	Medium	R4.2 Before Transformation Projects are put forward for review and approval, the Health Board should ensurethat SMART criteria for measuring a project's development and "what success looks like" aredefined, and theaccounting structures to be applied to record each project are documented and subject to review.	Agreed. Each Programme should have benefits criteria agreed by its own Programme Governance and signed off by the Clinical Futures Programme Board (HSLG). The SRO should lead the development of the benefits measures with support from business partners and programme leads Finance Leads to be allocated to IMTP priorities programmes. Accounting of efficiency and savings progress to be captured in financial management information packs.	31/07/2022	N/A	N/A	Not yet due	-3	#VALUE!						07/05/2022	30/06/2022
2021.18	Internal	Financial Sustainability	Reasonable	Director of Finance, Procurement & Value	Assistant Finance Director	Low	R4.3 The Health Board should ensure that Transformation Projects areexpressed as financially sustainable with identified funding from redeployment of existing budgets and/or non-recurrent funding sources.	Agreed in principle. Recommendations from programme workstreams will be considered through organisation planning, reporting andgovernance arrangements ultimately to Executive Team and the Board.	30/06/2022	N/A	N/A	Not yet due	-2	#VALUE!						07/05/2022	30/06/2022
2021.18	Internal	Financial Sustainability	Reasonable	Director of Finance, Procurement & Value	Assistant Finance Director	Low	R4.4 There is an inherent risk that elements of non-recurrent funding of Transformation Projects are not forthcoming in future years. Any decision to continue projects without an identified recurring source of income risks financial sustainability in future years.Therefore, the Health Board should consider developing a clear mechanism to compare projects to allow for clear decision making where funding resources are limitedandthere may be a need to prioritise Transformation Projects.	Agreed. Aprioritisation process to support resource allocation as part of IMTP development is being developed by the Executive team for consideration by the Board.	30/06/2022	N/A	N/A	Not yet due	-2	#VALUE!						07/05/2022	30/06/2022
2021.20	Internal	Medicines Management	Reasonable	Medical Director	Senior Primary Care Pharmacist	Low	R1 Management should review the terms of reference (ToR) for theGwent Controlled Drugs Local Intelligence Network,including its quoracyrequirements. Meetingsthatare not quorate should either be deferred or recognised at the start of the meeting ensuring those in the meeting understand the implications of this.The requirement to complete minutes and action logs after each meeting should also be added to the ToR.	The terms of reference of the Gwent CDLIN will be reviewed and updated as requested at the next CDLIN on 1stAugust 2022.1.The TOR will be updated to remove need for Police representation at each member.2.To recognise any non-compliance with quoracy requirements at the start of any meeting. The implications of this to be noted in the minutes. 3.To add the requirement to complete minutes and action logs after each meeting will be added to the TOR.	31/08/2022	N/A	N/A	Not yet due	-4	#VALUE!						07/05/2022	30/06/2022
2021.20	Internal	Medicines Management	Reasonable	Medical Director	Head of Pharmacy - Operational Services/Principal Technician, Pharmacy Technical Services	Medium	R2.1 Management should review the Policy for the Management of Controlled Drugs and update where required.	The CD Policy is due for review during 2022/23. As in previous reviews a working group with representatives from Pharmacy and nursing will be set up to update the policy. A number of sections and standard operating procedures will be updated to make the policy more relevant and practical. This will support compliance with the policy. Controlled drug keys being held on their own may have been best practice. However, this may not be convenient on the wards. This could be removed in the updated version.The use of red pen on the wards is to make stock checks morevisible. The practicality of this will be reviewed.Keeping patients own CDs on a separate shelf may not always be possible. However, they should be clearly differentiated from ward stock.The policy will also include a description of the audit framework that will provide assurance the policy is being followed.	31/03/2023	N/A	N/A	Not yet due	-11	#VALUE!						07/05/2022	30/06/2022
2021.20	Internal	Medicines Management	Reasonable	Medical Director	Head of Pharmacy - Operational Services/Principal Technician, Pharmacy Technical Services	Medium	R2.2 Once the Policy for the Management of Controlled Drugs is updated, the Health Board should undertake periodic reviews to ensure wards are adhering to the updated Policyand confirm the areas of non-compliance identified as part of this review have been rectified.	The stand operating procedure for pharmacy 6 month stock check on the wards is being updated by a Principal Pharmacy Technician. This will include updating the way reconciliation checks confirmation are documented to ensure compliance.The policy can include the need for periodic audits to review use of the policy and confirm areas of non compliance have been rectified.	31/03/2023	N/A	N/A	Not yet due	-11	#VALUE!						07/05/2022	30/06/2022
2021.20	Internal	Medicines Management	Reasonable	Medical Director	Head of Pharmacy - Operational Services/Principal Technician, Pharmacy Technical Services	Medium	R3. Management should continue as planned to add the Omnicell user guides to Sharepoint and direct staff to this learning material. The guides should be useful to the front end user and also to Ward Managers regarding the reporting capabilities within anOmnicellmachine.	There are user guides for both end and superusers provided by Omnicell. The Principal Pharmacy technician at RGH has developed basic user guides for the wards which detail the common functions with picture guides. These are available on the wards, but staff cannot always find them. The plan is to add them to SharePoint and signpost staff to them. Short training videos are also to be developed which will be uploaded toYouTube. QR codes will be placed on the side or front of the cabinet and linked to the videos which will show staff how to maximise the Omnicells functionalities.	31/08/2022	N/A	N/A	Not yet due	-4	#VALUE!						07/05/2022	30/06/2022
2021.20	Internal	Medicines Management	Reasonable	Medical Director	Head of Pharmacy - Operational Services	Medium	R4 The PharmacyTeamshould comply with the relevant Health Board policies and SOPs for controlled drugs, in particular the removal of expired controlled drugs and the completion of six-monthlystock reconciliations(which should all be completed in a consistent manner). Where compliance with the policycannot be achieved, for example due to resourcing, an agreed temporary deviation from the Policy should be agreed and approved at anappropriateGroup.	A full review will be conducted into the Pharmacy processes relating to 6-monthly CD stock reconciliations to determine the extent of the issue and to provide assurance of compliance. The Pharmacy Team will input into the Management of Controlled Drugs Policy, with the potential to visit the mechanism of how expired drugs are reported to Pharmacy, to ensure a more robust system with auditable records is available in the future.	30/09/2022	N/A	N/A	Not yet due	-5	#VALUE!						07/05/2022	30/06/2022
2021.22	Internal	NIS Directive (Cyber Security)	Reasonable	Director of Planning, Performance, Digital & IT	Chief Digital Officer	Low	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	N/A	N/A	Not yet due	-8	#VALUE!						07/05/2022	30/06/2022
2021.22	Internal	NIS Directive (Cyber Security)	Reasonable	Director of Planning, Performance, Digital & IT	Chief Digital Officer	Medium	R2 Management should ensure that records of discussions and information provided to and from the CRU are captured for future annual self-assessments.	Management will ensure that during any future self-assessments records of discussions and informationsupplied to the CRU will be captured and available for internal or external review.	31/12/2022	N/A	N/A	Not yet due	-8	#VALUE!						07/05/2022	30/06/2022
2021.22	Internal	NIS Directive (Cyber Security)	Reasonable	Director of Planning, Performance, Digital & IT	Chief Digital Officer	Medium	R3 Management should ensure that an Improvement Action Plan is developed promptly in order to avoid delays in implementation.	NIS Improvement Plan is already being developed by the Cyber Team. Thecompleted plan willbe presented for management review and sign off. Currently ABUHB are still awaiting the publication ofCAF Based Cyber Risk Register for the Health Board these risks identified by CRU following the CAF assessment may include remediations that will be incorporated into the Improvement Plan currently being	31/07/2022	N/A	N/A	Not yet due	-3	#VALUE!						07/05/2022	30/06/2022
2021.22	Internal	NIS Directive (Cyber Security)	Reasonable	Director of Planning, Performance, Digital & IT		Medium	R4 The costs associated with the improvement actions should be assessed and reported to a relevant committee to enable awareness of the full picture and prioritisation of actions and funding.	The NIS Improvement Plan will be submitted through the relevant governance committee for senior Management review and sign off. Prioritisation of remedial actions and related costs will be assessed through ABUHB formal risk governance structureand relevant committees. Note ABUHB are currently implementing the recommendations of the Templar consultancy report which will create the Office of the SIRO and create a new governance frameworkto support Risk Management within the Health Board.	30/09/2022	N/A	N/A	Not yet due	-5	#VALUE!						07/05/2022	30/06/2022
2021.22	Internal	NIS Directive (Cyber Security)	Reasonable	Director of Planning, Performance, Digital & IT	Chief Digital Officer	Medium	R5 A formal reporting route for cyber security should be established to ensure that senior staff are aware of the position relating to cyber security.5.2The risk description should be reviewed, with inclusion of the potential financial penalties relating to noncompliancewith NIS.	ABUHB are adopting recommendations of the Templar Report that will establish a formal risk governance and committee structure within the Health Board which will support Cyber Security Risk Reporting.5.2As part of the improvements suggested by Templar a new Cyber Risk Register will be developed. As part of development process account will be taken to include the financial penalties associated with noncompliance to NIS regulatory requirements into the assessment methodology and reporting.	30/09/2022	N/A	N/A	Not yet due	-5	#VALUE!						07/05/2022	30/06/2022
2021.23	Internal	Operational Resumption of Services	Reasonable	Director of Operations		Medium	R1 The Health Board shouldreview and update service deliveryplanstoset outthe revised delivery timeframes for addressing the current backlog ofRTT waiting lists.	Ongoing work using SFN data in collaboration with Planning to determine the modelling requirements. We will update monthly trajectories in line with the quarterly update process agreed with the IMTP Plans assessed weekly against trajectories –reported monthly to Executive team and Board via the Integrated Performance report	31/07/2022	N/A	N/A	Not yet due	-3	#VALUE!						07/05/2022	30/06/2022
2021.23	Internal	Operational Resumption of Services	Reasonable	Director of Operations		Medium	R2 The Health Board shouldreview the current performance reportingfor the resumption of servicesand incorporate metrics to monitor the effectiveness of actions undertaken and the profile of the overall reduction of the waiting lists.	Performance is measured weekly actual v planned and set against the agreed trajectories as per IMTP Weekly performance meetings reinstated with Divisions and chaired by the Director of Operations	30/06/2022	N/A	N/A	Not yet due	-2	#VALUE!						07/05/2022	30/06/2022
2021.24	Internal	Flow Centre	Reasonable	Director of Operations	Service Manager (USC)	Medium	R1.1 The Flow Centre Team should ensure that the reason for an aborted transfers should be adequately recorded.	The Flow Centre Team have performed regular audits throughout the year and learning outcomes identified. This recommendation features on our regular 1:1s with individuals, staff weekly updates and will be a focus over the next fewmonths in line with this audits recommendation.Assurance is given via the Operations Structure and Urgent Care Divisional meetings with a monthly frequency and contain a feedback loop to ensure learning is disseminated to the teams.Flow Navigator audit tool to be created. Key area of focus for our Flow Navigator Auditor over the next 2 months	31/07/2022	N/A	N/A	Not yet due	-3	#VALUE!						07/05/2022	30/06/2022
2021.24	Internal	Flow Centre	Reasonable	Director of Operations	Flow Centre Nurse	Medium	R1.2 The Flow Centre Team should ensure that the reason for an aborted transfers should be adequately recorded.	This audit has highlighted a key learning outcome regarding the process followed when closing calls on the system and the loophole associated with the system used for recording the referral (Nugensis).Learning identified and training provided to staff Key area of focus for our Flow Navigator Auditor over the next 3 months	31/07/2022	N/A	N/A	Not yet due	-3	#VALUE!						07/05/2022	30/06/2022
2021.24	Internal	Flow Centre	Reasonable	Director of Operations	Flow Centre Nurse	Low	R2 The Flow Centre Team should establish the required level of information to be documented on the Transfer Form for each patient screenedand all forms should be uploaded onto CWS.	In the past 3 months an internal audit performed by the department highlighted further evidence of this practice and an action plan has been implemented to improve this area of practice.Clinical audit tool to be created. Initial audit to be completed –5% of Flow Nurse workload. Learning identified and training provided to staff	30/09/2022	N/A	N/A	Not yet due	-5	#VALUE!						07/05/2022	30/06/2022
2021.24	Internal	Flow Centre	Reasonable	Director of Operations	Flow Centre Nurse	Low	R3 The Flow Centre Team should develop key performance indicators to help improve the delivery of the service, manage key risks and to help develop staff.	With recent changes in clinical and operational leadership of the Flow Centre a focus will be on creating these key performance indicators (KPI) and stabilising the services as we recover from the impact of COVID. Create operational KPI for Pre-Hospital Screening. Create clinical KPI for Intersite transfer service. Review the clinical and operational model of the Flow	30/09/2022	N/A	N/A	Not yet due	-5	#VALUE!						07/05/2022	30/06/2022
2021.24	Internal	Flow Centre	Reasonable	Director of Operations	Service Manager (USC)	Medium	R4.1 We recommend that the Flow Centre Team review and update the business continuity plan, where required	The business continuity plan is being reviewed and updated currently.	30/06/2022	N/A	N/A	Not yet due	-2	#VALUE!						07/05/2022	30/06/2022
2021.24	Internal	Flow Centre	Reasonable	Director of Operations	Service Manager (USC)	Low	R4.2 We recommend that the Flow Centre Team periodically test their business continuity plan and update it with learnings from the exercise(s).	A planned test of the business continuity plan will be initiated by the target date. An unplanned test of the business continuity plan will be initiated by the target date	30/10/2022	N/A	N/A	Not yet due	-6	#VALUE!						07/05/2022	30/06/2022
2021.24	Internal	Flow Centre	Reasonable	Director of Operations	Service	Medium	R5 The Flow Centre Team should provide	The Flow Centre has been operational for	30/08/2022	N/A	N/A	Not yet due	-4	#VALUE!						07/05/2022	30/06/2022

ABUHB	Audit Type	Report Title	Assurance	Director	Responsible	Ref /	Recommendation	Management Response	Agreed	Revised	Revised	Due	No. of	No. of months	If closed	Progress being made to implement recommendation				Reporting Date	Date Added to
	External	Structured Assessment 2019	Not Rated	Director of Planning, Performance, Digital & IT		Not rated	R3 Board updates on Clinical Futures do not include information on whether planned actions/mitigation are effective, and it is unclear whether risks no longer reported have been eliminated. The Health Board should include information on the effectiveness of risk mitigation in its board updates.	This will be added to future reports.	31/03/2020	N/A	N/A	Overdue	**25**	#VALUE!						07/05/2022	Identified as outstanding in Structured Assessment 2021 - As the Health Board moves into the recovery phase of the pandemic, it should consider how progress on the Clinical
	External	Structured Assessment 2019	Not Rated	Director of Planning, Performance, Digital & IT		Not rated	R4 The recent report to the Finance and Performance (F&P) Committee on progress against the IMTP SCPs did not include progress against the relevant high-impact priorities aligned to them. The Health Board should ensure that committee reports on SCP progress clearly link relevant high-impact priorities with the achievements set out.	Reports have been made on SCPs to Finance and Performance Committee and the Board. This will be regularised in 2020 through the committee and Board forward work programme.	31/03/2020	N/A	N/A	Overdue	**25**	#VALUE!						07/05/2022	Identified as outstanding in Structured Assessment 2021 - The Health Board is developing a monitoring and outcomes framework that will enable the Board to monitor, scrutinise and challenge
	External	Structured Assessment 2017	Not Rated	Director of Finance, Procuement and Value		High	R1 The Health Board should provide more detail to Executives and Independent Members in respect of progress against savings schemes. This should help them to provide sufficient scrutiny and challenge to schemes which are off target.	Current reporting to Board and Finance and Performance Committee (F&PC) provides a summary of savings plans, risk and deliverability. We will look at how to enhance the reporting to ensure that the level of delivery/financial risks is clearly understood both at Board level and where further scrutiny is required at F&PC. This is in addition to the detailed information which is already produced monthly to support Divisional financial assurance meetings	30/04/2018	N/A	N/A	Overdue	**48**	#VALUE!						07/05/2022	Identified as outstanding in Structured Assessment 2021 - Finance reports provide an overview of Health Board savings progress to date and performance of its high level 'green' savings schemes.
	External	Structured Assessment 2017	Not Rated			High	R7 The Health Board should review, refresh and update the Engagement Strategy – 'Hearing and acting upon the voice of our staff and citizens'.	The Health Board will undertake a review and refresh its Citizen Engagement Strategy in line with the Clinical Futures Programme and IMTP. The Health Board will also continue to take forward its programme of staff engagement in line with the Clinical Futures Programme.	31/07/2018	N/A	N/A	Overdue	**45**							07/05/2022	Identified as outstanding in Structured Assessment 2022 - With the merger of the communications and engagement functions, the Health Board, will review and refresh both
	External	Structured Assessment 2017	Not Rated	Director of Planning, Performance, Digital & IT		High	R5 The Health Board should ensure resources allocated to information technology and information management provide sufficient capacity to meet the Health Boards plans	A Strategic Outline Plan was developed for the Welsh Government in October 2016, which asked for a cost analysis to implement the Welsh Government E-Health and Care Strategy to assess the potential resource implications for Wales. The Health Board is currently revisiting the Strategic Outline Plan and Strategy in the light of the financial context and has also developed a new IMTP for Digital with ten priority areas linked to this Plan. The Health Board has undertaken a review and benchmarking exercise in order to develop a sustainability business case	31/03/2019	N/A	N/A	Overdue	**37**							07/05/2022	Identified as outstanding in Structured Assessment 2022 - There has continued to be increased investment in informatics both in terms of capital and revenue to help progress the digital strategy
	External	Structured Assessment 2018	Not Rated	Director of Planning, Digital and IT		High	R4 The Health Board should address areas for improvement in relation to informatics, specifically updating ICT disaster recovery plans and test these to ensure they worked as intended.	key appointments have now been made against a number of positions relating to cyber security. Work is being completed on key personnel polices plans and underlying services. Work is ongoing with the newly recruited team in compliance with NISD. A Task and Finish group is currently prioritising and planning continuity arrangements led by the Emergency Planning Team.	31/03/2020	N/A	N/A	Overdue	**25**	#VALUE!						07/05/2022	Identified as outstanding in Structured Assessment 2022 - progress made but not complete
	External	Structured Assessment 2018	Not Rated	Director of Planning, Digital and IT		High	R3 The Health Board should improve its information governance arrangements by: • improving compliance with the information governance training programme to reach the national rate of 95%;	Information Governance training reviewed to include the legislation changes as a result of GDPR. An additional module was developed and launched for Cyber Security which is mandatory for all staff to complete. The Information Governance Unit has set up Information Governance Delivery Groups (IGDG) for each of the Divisions in the organisation. The meetings are held bi monthly and training is included on the agenda for every meeting. Discussions are held specifically around compliance and Managers are tasked with improving their compliance rates. Reports are assessed at Transformation to Digital (T2D) Delivery Board.	01/03/2020	N/A	N/A	Overdue	**26**	#VALUE!		November 2021 Update: IGDG meetings will now include Cyber respresentation to ensure a comprehensive coverage of Governance across the organisation. The meetings have been sporadic due to COVID and winter pressures. IG have plans in place to target specific areas of non-compliance service areas. This work will commence at the beginning of 2022 due to winter pressures. Compliance has increased to 78% and the team are working towards achieving the 85% compliance which is mandated in the Information Governance Toolkit.		Non compliance reports are being sent to senior managers within Divisions to ensure that compliance is monitored and actioned in these areas. Where non-complance persists targeted escalation routes have been established and the appropriate corrective action will be taken. Promotion of the audio learning tool for staff groups that have dificulty in leaving the workplace or access to computer systems and e-learning will be facilitated by the IG team and attendance recorded.		07/05/2022	Identified as outstanding in Structured Assessment 2022 - The pandemic has hindered progress against achieving the national rate of 85% with compliance for the organisation currently reported at 74%
202102	External	Radiology services: follow-up of 2017 recommendations	Not Rated	Director of Operations	Radiology Directorate Manager	Not rated	R4 The Health Board should look to further develop its collection of patient experience information across its sites and seek to identify any common trends that can be actioned to improve the service. Follow up 2021 - Whilst the Health Board has made positive progress against this recommendation, we feel unable to close this recommendation until the Health Board has implemented the site-specific PREM and reintroduced the comments box. In terms of learning, it would be helpful for the Health Board to identify how learning from patient feedback has made a difference and led to improvements.	TBC	31/03/2018	N/A	N/A	Overdue	**49**	#VALUE!						07/05/2022	25/03/2022
202101	External	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Finance, Procurement & Value		High	The HealthBoard should hold workshops with Audit Wales to discuss what information is required to provide assurance for the audit, and what are the best ways of obtaining this.	A workshop will be arranged with Audit Wales in January 2022 to ascertain the information required in order to substantively test payroll transactions. Relevant Health Board employees will be invited to attend this workshop to ensure that going forward information is provided in the format required and on a timely basis.	31/01/2022	N/A	N/A	Overdue	**3**	#VALUE!						07/05/2022	25/03/2022
202101	External	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Planning, Performance, Digital & IT		Medium	The HealthBoard should consider strengtheningtheirIT Controlsas follows:i.All of the Windows server 2008 operating system should be replaced with either or Windows 2012 or higher where possible (this is almost completed with only twenty three servers left). ii.W7 and W8.1 desktop devices should be replaced as these are now de-supported. iii.Ensure that the change management procedure is finalised.iv.The IT Data Recovery Plan and Backup Policy should be updated and clearly defined.v.With regards to the Wellsky system, leavers and accesses changes should beformally recorded, and the Health Board shoulddevelop a suite of audit and security reports to run and monitor to ensure user access is appropriate.	i.With regards to our Windows Server 2008 environment, we have an active programme of work to either upgrade or decommission these servers. It is envisaged that by the end of the current quarter only a few servers may remain, although weare currently investigating options for these.ii.ABUHB have made significant progress in removing Win7/8.1 from our estate and currently have 0.4% to complete.There is an active programme of work to remove these devices from the network or upgrade them toa supported version of Win10.iii.We have an established and robust Change Management Process in place with regularly scheduled and structured Change Advisory Board meetings to manage operational change.The process has been widely socialised with all of Informatics and other Key Stake Holders, and also engages effectively with other ITIL practices such as Incident Management and Asset/Configuration Management.Critical Success Factors and Key Performance Indicators are agreed and monitored to measure effectiveness.iv.The IT Data Recovery Plan and Backup Policy is still in the process of being reviewed and updated.A draft version has been shared within the team and the finalised version will be released within	31/12/2021	N/A	N/A	Overdue	**4**	#VALUE!						07/05/2022	25/03/2022

Aneurin Bevan University Health Board

Recovery of Overpayments to Employees 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. Introduction

This policy sets out how overpayments to staff arising from the payroll, expenses or other Health Board payment systems are recovered.

2. Policy Statement

The policy sets out a fair process so that all staff are treated equitably in a situation where an overpayment occurs.

3. Aims

To ensure all overpayments are recovered as quickly as possible without imposing undue financial hardship on staff and that staff are treated fairly and consistently.

4. Objectives

This policy sets out a process for overpayments to be recovered when they arise that is fair and takes due regard to personal financial circumstances of staff when this presents difficulties in prompt repayment. It clearly sets out the role of Payroll Services, Corporate Finance, line managers, staff and the Counter Fraud department who are all involved in the process.

5. Scope

This policy relates to all staff within the Aneurin Bevan University Health Board. The scope of the policy covers both manual and electronic systems. The vast majority of overpayments occur in the payroll system and so 'Payroll' is referenced through this document but must be interpreted to be any payment system such as the expenses or accounts payable systems.

6. Roles and Responsibilities

6.1. All Staff

It is the responsibility of all employees to ensure their pay is correct. Employees must check their payslips via Employee online (ESR) and alert their manager and Payroll Services immediately if they suspect an over or underpayment has been made.

6.2. Line Managers, Managers and Supervisors

Must ensure that all payroll documentation e.g.:

- Enrolment forms
- Change Forms
- Termination forms
- Manager Self Service

Is completed and submitted immediately on notification by the employee of a change via the Manager Self-Serve in ESR or in exceptional circumstances manually. For example if a member of staff hands in a resignation the Termination notification must be actioned immediately (at point of resignation) even if there is a period of notice to be worked.

The same principle of timely submission of information holds for data transmitted via ESR Manager Self Service.

Untimely submission of payroll documentation/MSS update can cause significant inconvenience and anxiety for staff and unnecessary additional administration for the organisation. If managers repeatedly fail to comply with the requirement to submit information in a timely manner they may be subject to formal processes.

If an overpayment is identified Payroll will notify the employee and the line manager. The manager must also notify the employee immediately in order that any queries can be discussed and resolved.

6.3. Payroll Services

Payroll Services will:

- Identify when overpayments have occurred through a number of possible sources - Typically staff or manager referral, audit and review processes, budget and financial management review.

- Initiate the process of recovery and determine whether a payment is classified as 'minor' or 'significant'.

- Notify the employee and the employee's manager.

- Respond to overpayment queries in a timely manner.

6.4. Corporate Finance

The Corporate Finance department will:

- Be responsible for issuing invoices to individuals to recover significant overpayments and process repayments.
- Negotiate payment terms within the parameters set out in this policy.
- Be responsible for initiating the appeals process and organising appeal meetings.
- Issue packs of evidence to all attending the appeal meeting at least 7 days in advance of the meeting.

6.5. Workforce and OD

Workforce and OD department will be responsible for:

- Participating in the Appeals Meeting.
- Communicating the Decision of the Appeals Panel.

6.6. Divisional General Managers

Divisional general managers will be responsible for:

- Chairing Appeals Meetings (which may or may not relate to individuals within their own division) OR:
- Nominating a deputy to chair Appeals Meetings, who must be of sufficient seniority to make independent outcome decisions.

6.7. Counter Fraud Department

The Counter Fraud department will:

- Investigate all significant overpayments and may pursue criminal prosecution if it is deemed that overpayments were dishonestly retained.

7. Main Policy Content

An overpayment is a payment for which an individual member of staff is not entitled and which has been made as a result of an administrative error or delay in processing of appropriate documentation.

Payroll Services will determine the type of overpayment that has occurred. The type and category of overpayment is important because it determines the repayment process. The classification of overpayments is as follows:

7.1. Type of Overpayment

7.1.1. Minor Overpayment

Where the overpayment has occurred over a period of 3 months or less and is less than 25% of normal net monthly or weekly pay of the employee.

7.1.2. Significant Overpayment

Where the overpayment has occurred for a period of more than 3 months or is greater than 25% of normal monthly or weekly net pay of the employee.

7.2. Category of Overpayment

Overpayments typically fall into a number of categories as follows:

7.2.1. Late Documentation/ Manager Self-Service Action

These arise because documentation is received late or ESR via Manager Self Service has not been updated in a timely manner leading to an overpayment. This will typically include late termination forms, late change forms notifying of a reduction in hours all of which can lead to staff being overpaid.

7.2.2. Calculation Errors

These are errors arising from a calculation of payments due for example the calculation of enhancements or overtime being incorrect. It may relate to incorrect information submitted to Payroll Services or an error by Payroll Services.

7.2.3. Interpretation Issues

These typically relate to a dispute about remuneration agreements and may relate to additional sessions or cover arrangements where this is a difference in interpretation of policy between the individual, Payroll Services and/or manager.

7.3. Overpayment Recovery Process

Appendix 1 shows the process diagram and is also described in detail as follows:

Payroll Services identify that an overpayment has occurred.

Payroll Services then determine the category of overpayment as one that is either 'Minor' or 'Significant' as defined in 7.1 above.

7.3.1. Minor Overpayments

Where a *minor overpayment*, as defined in 7.1.1 above, has been made the employees pay will be adjusted in the next pay period to reclaim the amount of the overpayment. Payroll Services will also notify the individual of the adjustment within 5 working days of the issue being made known to the Team setting out the reasons and appropriate calculations. See Appendix 2.

Where an overpayment is defined as *minor* and has occurred over a consecutive period of up to 3 months the recovery will be actioned over the same time frame.

7.3.2. Significant Overpayments

Where a *significant overpayment*, as defined in 7.1.2 above, has been made the employee and manager will be notified in writing, by Payroll Services, within 10 working days of the issue being made known to the Payroll Services Team and confirmed.

Payroll Services will send the completed overpayment letter set out in Appendix 3 to the Corporate Finance Department, within 10 working days of the issue being made known to the Payroll Services team and confirmed. The Corporate Finance Department will send the letter to the employee accompanied by an invoice for the amount due for repayment. Payroll Services will also send a letter to the manager notifying them of the employee overpayment as set in Appendix 4.

7.3.3. Staff Who Have Left the Organisation

Where an overpayment is discovered and the employee has terminated their employment then recovery cannot be made via Payroll Services and so all recoveries will be deemed as *significant overpayments* for the purpose of recovering any outstanding amounts.

7.3.4. Debt Recovery Process

Once an invoice has been sent to the individual the recovery process will be subject to the Accounts Receivable Financial Control Procedure which is available on the intranet. The debt recovery process is summarised from the policy as follows*:*

- *Invoice is issued for the net amount overpaid to employee after tax, NI and pension deductions with letter and supporting calculations.*
- *If the invoice remains unpaid a reminder letter is issued after 21 days.*
- *A second reminder is sent at 42 days.*
- *The Debt is referred to debt collection agents to attempt recovery after 56 days.*
- *The Debt is referred to court for recovery where recovery by the debt collection agency has not been successful.*

7.4. Repayment of Debt and Repayment Terms

Once an invoice has been issued to the employee the invoice must be paid as soon as possible to avoid escalation as shown in 7.3.4 above. However, if the employee has difficulty repaying the debt, then extended terms of repayment can be agreed provided:

- The Corporate Finance Department- Accounts Receivable Section is contacted immediately.
- The employee can demonstrate financial hardship with immediate repayment, through documented evidence of correspondence with a recognised debt support service.
- There has been no fraudulent retention of an overpayment by the employee.

A principle of '*matching*' repayments to the period that the overpayment occurred will be adopted if requested, *provided there has been no fraudulent retention of overpayments proven*.

A request to extend the repayment period beyond the matching period will be discussed with the Corporate Finance team, on receipt of the documented correspondence between the individual and a recognised debt support service, or via referral to the Health Board's contracted Debt collection agents (which would have no impact on the individuals credit score). This should be received by the Health Board within 21 days of the first reminder letter.

If financial hardship can be demonstrated, then an extended repayment period can be agreed, but will be subject to an administration fee of £1 per transaction from the end of the matching period. This will require approval by the Assistant Finance Director (Financial Systems and Services).

7.5. Payroll Query Process

If the member of staff doesn't agree with the overpayment calculations provided, or requires further explanation of how the overpayment arose, staff should contact the Payroll Team via NWSSPOverpaymentsSE@Wales.nhs.uk, as provided on the overpayment letter.

The Payroll Overpayment Team will respond to queries in a timely manner (no later than *10 working days*), ensuring that the query doesn't affect the Debt Recovery process managed by the Corporate Finance team.

7.6. Appeal Process

An Appeal Process is available where there is failure to agree that the overpayment is valid. The Appeal Process covers both *Minor* and *Significant* overpayments as defined in 7.3 above.

Where an overpayment is defined as a *calculation error or interpretation issue* the employee has the right to appeal against the overpayment if they consider the overpayment to be incorrect. If the overpayment is defined as *'Late Documentation'* then there is no right to appeal other than in exceptional or unusual circumstances.

In the first instance the employee must ensure that there is full communication with the line manager and Payroll Services to try to resolve the issue. Where an overpayment has occurred due to a Manager or ABUHB error the Payroll Services Team can only resolve any questions that may arise in respect of the calculation of the overpayment. Any resolution in respect of the principle of the overpayment will be a matter between the employee and manager. If this fails to reach agreement the employee must instigate the appeal via the Corporate Finance Department-Accounts

Receivable Section Head. The Accounts Receivable section will inform the employees' line manager.

The Accounts Receivable Section will place the invoice 'on hold' pending the outcome of the appeal. The Appeal must be requested within 21 days of the letter informing the employee of an overpayment.

An Appeal Panel will meet (organised by Corporate Finance) on a periodic basis to consider appeals and will comprise the following staff with no conflict of interest in the case:

- Divisional General Managers (Chair)
- HR senior manager
- Corporate Finance manager
- Staff side representative (not associated with the employees Trade Union)

In attendance at the meeting will also be:

- Employee and Trade Union representative if required
- Payroll manager
- Employee line manager

The Appeal Panel is an opportunity to examine the evidence and allows the employee concerned the proper opportunity to comment on the evidence and make any representations or offer their views concerning the overpayment. The Appeal Panel must consider all the evidence and give the employee a fair opportunity to make their views known whilst at the same time ensuring that all evidence is examined thoroughly so that an appropriate decision can be reached. No new written evidence may be produced by either party after the exchange of case papers without the agreement of all parties.
The Panel will ensure that:

- Full and fair consideration will be given to all issues pertinent to the case.
- All evidence will be considered, and
- That the employee or their representative will have the opportunity to present their case.

Appropriate documentation and evidence supporting the appeal must be sent to Corporate Finance and made available to the attendees within 7 days of the appeal.

If the original appeal date is not suitable, an alternative date will be arranged to suit all parties. If the second appeal date is not attended, then Corporate Finance will then pursue the debt in line with policy.

If the appeal is not upheld then the debt collection will follow the Normal Accounts Receivable Policy with no further right to appeal. The outcome of the appeal is final.

7.7. Recovery of Income Tax, NI and Pension Deductions

The net cash overpayment is recovered from an employee. Associated income tax, national insurance and pension contributions will be recovered from HMRC and the pension agency by Payroll Services relating to all incidences of employee overpayments.

7.8. Counter Fraud Referral

Employees should be aware that it is considered to be an offence to retain money to which they knowingly have no entitlement and is considered Theft contrary to Section 1, the Theft Act 1968. Failing to notify Aneurin Bevan University Health Board that a mistake has been made by paying an individual more than they are entitled is also an offence contrary to Section 1.3 of the Fraud Act 2006.

An employee therefore has a duty to immediately report any such incidences to Payroll Services.

On receipt of the Overpayment Letter from Payroll Services, Corporate Finance will refer all *significant* overpayments to Counter Fraud for further investigation. Where clear intent to withhold disclosure of an overpayment is established criminal proceedings may be invoked.

7.9. Death in Service

Where an overpayment is outstanding relating to an employee who is deceased the debt would normally be recovered through the deceased's Estate as set out in Appendix 5. In exceptional circumstances this can be waived by the Executive Team of the Health Board.

7.10. Overpayment waiver

Under no circumstances can a manager waiver the overpayment. If an employee disputes an overpayment which cannot be resolved, the employee in certain circumstances can request an appeal.

8. Equality

An Equality impact Assessment has been completed.

9. Audit

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

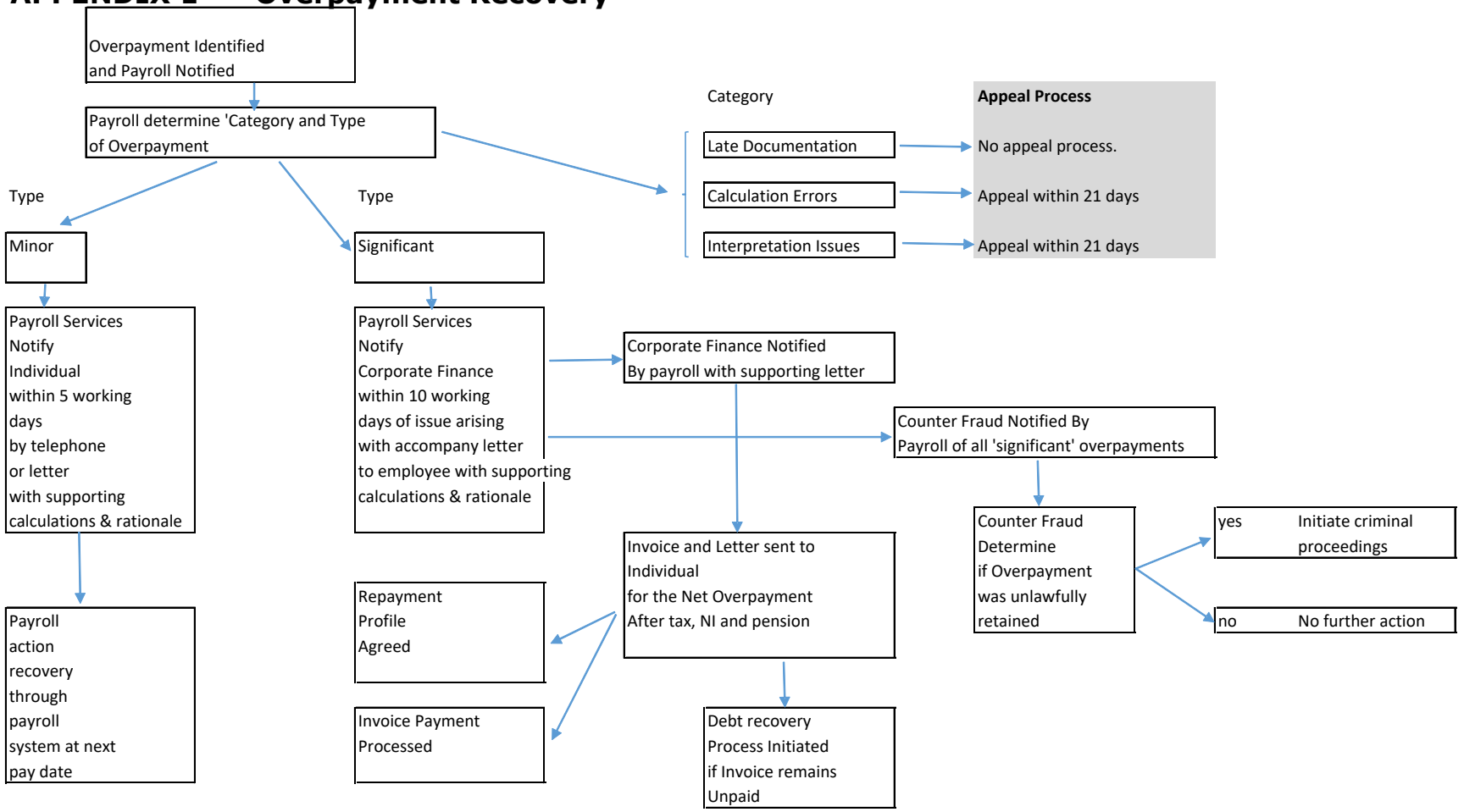
10. Review

This policy will be reviewed every 3 years.

11. Further Policies for Consideration

- Capability Policy
- Disciplinary Policy

APPENDIX 1 Overpayment Recovery



APPENDIX 2 Minor Overpayment Letter

South East Wales Overpayment Team
4th Floor
Companies House
Crown Way
Cardiff
CF14 3UB
02920 903908
NWSSPOverpaymentsSE@Wales.NHS.UK

Our Ref: JEC/JS/040/[insert initials] /[Click here to insert assignment number]

DATE HERE]

PRIVATE & CONFIDENTIAL

[Click to enter Name]
[click to enter address]

Dear [Click to enter Name]

Re: OVERPAYMENT OF SALARY

I regret to inform you that Payroll Services have been made aware of an overpayment of salary. It relates to the period [Insert Dates from - to] . According to our records, this overpayment arisen because [Click to enter reason for overpayment] .Please accept my sincere apologies for this administrative error and any inconvenience it may cause you.

The overpayment is calculated as follows:-

£[Insert Gross Overpayment]

The organisation recognises that overpayments are regrettable and may cause staff anxiety. The organisation therefore ensures that any overpayment of salary or expenses are recovered from employees in a consistent manner. The organisation has therefore developed a policy to deal with overpayments that can be accessed via the following Intranet Link Recovery of Overpayments to Employees

In line with the policy this overpayment has been categorised as a 'Minor' overpayment and will be recovered by adjusting your pay in the next pay period.

If you do not agree with the overpayment calculations provided, please contact the Payroll Team using the contact details at the beginning of this letter, who can assist with your enquiry.

Yours sincerely,

Choose an item.

NHS Wales Shared Services Partnership (NWSSP)
On behalf of Aneurin Bevan University Health Board

Tîm Gordaliadau De-ddwyrain Cymru
4ydd Llawr
Tŷ'r Cwmnïau
Ffordd y Goron
Caerdydd
CF14 3UB
Rhif Ffôn: 029 20903908
NWSSPOverpaymentsSE@Wales.NHS.UK

Ein Cyf: JEC/[Initials] /040/[assignment number]

[date]

PREIFAT A CHYFRINACHOL

[Name and address]

Annwyl [name]

Parthed: GORDALIAD CYFLOG

Mae'n ddrwg gennyf eich hysbysu bod Gwasanaethau'r Gyflogres wedi cael gwybod bod gordaliad cyflog wedi digwydd. Mae'n ymwneud â'r cyfnod [Insert Dates from - to] . Yn ôl ein cofnodion, mae'r gordaliad wedi digwydd oherwydd Choose an item. A wnewch chi dderbyn fy ymddiheuriadau diffuant am y camgymeriad gweinyddol hwn ac unrhyw anghyfleustra y gallai ei achosi i chi.

Mae'r gordaliad wedi'i gyfrifo fel a ganlyn:-

£[Insert Gross Overpayment]

Mae'r sefydliad yn cydnabod bod gordaliadau yn anffodus ac y gallant achosi pryder i staff. Felly, mae'r sefydliad yn sicrhau bod unrhyw ordaliad cyflog neu dreuliau yn cael ei ad-dalu gan weithwyr mewn modd cyson. Felly, mae'r sefydliad wedi datblygu polisi i ymdrin â gordaliadau y mae modd mynd ato drwy ddilyn y Ddolen Fewnrwyd Ad-ennill Gordaliadau i Gyflogeion

Yn unol â'r polisi, mae'r gordaliad hwn wedi'i gategoreiddio fel gordaliad 'Mân' a bydd yn cael ei adennill trwy addasu eich cyflog yn y cyfnod tâl nesaf.

Os nad ydych yn cytuno â'r cyfrifiadau gordaliad a ddarperir, cysylltwch â Thîm y Gyflogres gan ddefnyddio'r manylion cysylltu ar ddechrau'r llythyr hwn, a fydd yn medru cynorthwyo gyda'ch ymholiad.

Yr eiddoch yn gywir,

Choose an item.

Partneriaeth Cydwasanaethau GIG Cymru (PCGC)
Ar ran Bwrdd Iechyd Prifysgol Aneurin Bevan

APPENDIX 3 Significant Overpayment Letter

South East Wales Overpayment Team
4th Floor
Companies House
Crown Way
Cardiff
CF14 3UB
Telephone Number: 029 20903908
NWSSPOverpaymentsSE@Wales.NHS.UK

Our Ref: JEC/initals/040/assignment

Date

PRIVATE & CONFIDENTIAL

Name and address

Dear

Re: OVERPAYMENT.

I regret to inform you that Payroll Services have been made aware that an overpayment of salary has occurred. It relates to the period ……..The overpayment has arisen because ……..Please accept my sincere apologies for this administrative error and any inconvenience it may cause you.

The overpayment is calculated as follows:-

Gross Overpayment		**£**
Less	Pension	£
	Tax	£
	National Insurance	£
	Student Loan	£
Net Overpayment		**£**

The organisation recognises that overpayments are regrettable and may cause staff anxiety. The organisation therefore ensures that any overpayment of salary or expenses are recovered from employees in a consistent manner. The organisation has therefore developed a policy to deal with overpayments that can be accessed via the following Intranet Link Recovery of Overpayments to Employees

An invoice is attached for the amount that you have been overpaid after deducting taxation, national insurance and pension contributions.

The normal terms for repayment of an invoice is 21 days, however if repayment within this time period causes financial hardship the policy does allow for extended repayment terms which are set out in section 7.4 of the policy.

If you do not agree with the overpayment calculations provided, please contact the Payroll Team using the contact details at the beginning of this letter, who can assist with your enquiry.

If your enquiry relates to the principle of the overpayment i.e. manager/organisation error please contact:-
Your manager

Where an overpayment has occurred due to late documentation there is no right to appeal and you should contact your manager to discuss the reason for the delay in submitting the documentation resulting in this overpayment.

If you consider the overpayment to be incorrect, the policy does allow a right of appeal. The appeal process is available on the Health Board's intranet site under the following link Recovery of Overpayments to Employees
If you are unable to view this policy please contact your line manager. You must log an appeal in writing with the Accounts Receivable Section of the Health Board within 21 days of the date of this letter. The Accounts Receivable Department can be contacted by E Mail on AREnquiries.ABB@wales.nhs.uk or by telephoning 01495 765469.
If an appeal is not logged within the 21 days the Health Board will apply our normal debt chasing procedures to this invoice.

Yours sincerely,

Choose an item.

NHS Wales Shared Services Partnership (NWSSP)
On behalf of Aneurin Bevan University Health Board

Tîm Gordaliadau De-ddwyrain Cymru
4ydd Llawr
Tŷ'r Cwmnïau
Ffordd y Goron
Caerdydd
CF14 3UB
Rhif Ffôn: 029 20903908
NWSSPOverpaymentsSE@Wales.NHS.UK

Ein Cyf: JEC/Init/ 040/Pay No

Date

PREIFAT A CHYFRINACHOL

Name and address

Annwyl

Parthed: GORDALIAD.

Mae'n ddrwg gennyf eich hysbysu bod Gwasanaethau'r Gyflogres wedi cael gwybod bod gordaliad cyflog wedi digwydd. Mae'n ymwneud â'r cyfnod [Click to add period] . Mae'r gordaliad wedi digwydd oherwydd ……. A wnewch chi dderbyn fy ymddiheuriadau diffuant am y camgymeriad gweinyddol hwn ac unrhyw anghyfleustra y gallai ei achosi i chi

Gordaliad Gros		£
Llai	Pensiwn	£
	Treth	£
	Rhif Yswiriant Gwladol	£
	Benthyciad i Fyfyrwyr	£
Gordaliad Net		£

Mae'r sefydliad yn cydnabod bod gordaliadau yn anffodus ac y gallant achosi pryder i staff. Felly, mae'r sefydliad yn sicrhau bod unrhyw ordaliad cyflog neu dreuliau yn cael ei ad-dalu gan weithwyr mewn modd cyson. Felly, mae'r sefydliad wedi datblygu polisi i ymdrin â gordaliadau mae modd mynd ato drwy ddilyn y Ddolen Fewnrwyd Recovery of Overpayments to Employees

Mae anfoneb ynghlwm am y swm y cawsoch eich gordalu ar ôl didynnu trethiant, Yswiriant Gwladol a chyfraniadau pensiwn.

Y telerau arferol ar gyfer ad-dalu anfoneb yw 21 diwrnod, fodd bynnag, os yw ad-dalu o fewn y cyfnod hwn yn peri caledi ariannol, mae'r polisi yn caniatáu ymestyn y telerau ad-dalu a nodir yn adran 7.4 o'r polisi.

Os nad ydych yn cytuno â'r cyfrifiadau gordaliad a ddarperir, cysylltwch â Thîm y Gyflogres gan ddefnyddio'r manylion cysylltu ar ddechrau'r llythyr hwn, a fydd yn medru cynorthwyo gyda'ch ymholiad.

Os yw eich ymholiad yn ymwneud ag egwyddor y gordaliad e.e. camgymeriad ar ran rheolwr/y sefydliad, cysylltwch â:

Rheolwr

Lle mae gordaliad wedi digwydd o ganlyniad i ddogfennaeth yn cael ei chyflwyno'n hwyr, nid oes hawl i apelio a dylech gysylltu â'ch rheolwr i drafod y rheswm dros yr oedi cyn cyflwyno dogfennaeth a arweiniodd at y gordaliad hwn.

Os ydych yn credu bod y gordaliad yn anghywir, mae'r polisi'n caniatáu hawl i apelio. Mae'r broses apelio ar gael ar safle mewnrwyd y Bwrdd Iechyd dan y ddolen ganlynol Recovery of Overpayments to Employees
Os nad ydych yn gallu gweld y polisi hwn, cysylltwch â'ch rheolwr llinell. Mae'n rhaid i chi gofnodi apêl yn ysgrifenedig gydag Adran Cyfrifon Derbyniadwy y Bwrdd Iechyd cyn pen 21 diwrnod o ddyddiad y llythyr hwn. Gellir cysylltu â'r Adran Cyfrifon Derbyniadwy drwy e-bost ar AREnquiries.ABB@wales.nhs.uk neu drwy ffonio 01495 765469.
Os na chofnodi'r apêl cyn pen y 21 diwrnod, bydd y Bwrdd Iechyd yn rhoi ei weithdrefnau mynd ar drywydd dyled ar waith ar gyfer yr anfoneb hon.

Yr eiddoch yn gywir,

Choose an item.

Partneriaeth Cydwasanaethau GIG Cymru (PCGC)
Ar ran Bwrdd Iechyd Prifysgol Aneurin Bevan

APPENDIX 4 Managers Letter

Southeast Wales Overpayment Team
4th Floor
Companies House
Crown Way
Cardiff
CF14 3UB
NWSSPOverpaymentsSE@Wales.NHS.UK

Date

[click here to enter name]

Dear Colleague

It has been identified that as a consequence of late completion and or submission or incorrect completion of payroll documentation or late action in Manager Self Service, the employee named has been overpaid.

Employee: [click here to enter employee name]

Assignment Number: [click here to enter assignment number]

Reason for overpayment: [click here to enter reason]

What To Do Now:

The employee has been issued with an invoice to repay the overpayment.

As the manager, you must meet with the employee to discuss the overpayment and ensure the employee understands the need to make repayment immediately. The employee will need to be made aware that where there is a failure to repay monies; Aneurin Bevan University Health Board will take legal action to recover the debt.

If there is any dispute in respect of the calculation of the overpayment the employee must contact Payroll Services in the first instance and discuss their rationale for querying it.

If the dispute is in relation to an 'Interpretation Issue' as set out in the Overpayment Policy it will be the responsibility of the Manager to resolve the dispute in the first instance. If the dispute cannot be resolved the employee has the right to an appeal, the process of which is set out in the Overpayments Policy. If the overpayment occurred because documentation was submitted late to the Payroll Services Department then it is the manager's responsibility to explain the reasons to the employee.

Yours sincerely,

NHS Wales Shared Services Partnership (NWSSP)
On behalf of Aneurin Bevan University Health Board

APPENDIX 5 Death in Service Letter

Southeast Wales Overpayment Team
4th Floor
Companies House
Crown Way
Cardiff
CF14 3UB
Telephone Number: 029 20903908
NWSSPOverpaymentsSE@Wales.NHS.UK

Our Ref: JEC/initals/040/assignment

Date

PRIVATE & CONFIDENTIAL

Name and address

Dear

Re: (input full name and assignment number).

ABUHB are sorry to hear of the death of (insert name) on the (insert date) and condolences are extended to the family for your loss at this time.

Whilst this is a sensitive issue to raise at this difficult time the Payroll Department has recalculated salary payment for (insert month and year) and unfortunately it has been calculated that an amount of £ (input value) is owing to Aneurin Bevan University Health Board in respect of the salary payments. When circumstances such as this arise the organisation has to seek repayment from the estate of the deceased employee. I would be grateful if you can ensure this information is passed to the Executors of the Estate for repayment to be made.

If you require any further information or assistance in respect of this matter, please do not hesitate to contact the Payroll Services Team using the contact details at the beginning of this letter, who can assist with your enquiry.
or the ABUHB Department Manager (insert name).

Yours sincerely,

Choose an item.

NHS Wales Shared Services Partnership (NWSSP)
On behalf of Aneurin Bevan University Health Board

Tîm Gordaliadau De-ddwyrain Cymru
4ydd Llawr
Tŷ'r Cwmnïau
Ffordd y Goron
Caerdydd
CF14 3UB
Rhif Ffôn: 029 20903908
NWSSPOverpaymentsSE@Wales.NHS.UK

Ein cyf: JEC/initals/040/assignment

Date

PREIFAT A CHYFRINACHOL

Name and address

Annwyl Name

Parthed: (Input full name and assignment number)

Mae'n flin gan Fwrdd Iechyd Prifysgol Aneurin Bevan glywed am farwolaeth (insert name) ar (insert date) a chydymdeimlir â'r teulu am eich colled ar yr adeg hon.

Er bod hwn yn fater sensitif i'w godi ar yr adeg anodd hon, mae Adran y Gyflogres wedi ail-gyfrifo taliad cyflog am (insert month and year) ac, yn anffodus, cyfrifwyd bod swm o £ (input value) yn ddyledus i Fwrdd Iechyd Prifysgol Aneurin Bevan o ran taliadau cyflog. Pan fydd amgylchiadau fel hyn yn codi, mae'n rhaid i'r sefydliad geisio ad-daliad gan ystâd y gweithiwr sydd wedi marw. Byddwn yn ddiolchgar os gallwch sicrhau bod yr wybodaeth hon yn cael ei throsglwyddo i Ysgutorion yr Ystâd ar gyfer gwneud ad-daliad.

Os oes angen rhagor o wybodaeth neu gymorth arnoch o ran y mater hwn, mae croeso i chi gysylltu â Thîm Gwasanaethau'r Gyflogres neu Reolwr Adran Bwrdd Iechyd Prifysgol Aneurin Bevan **(insert Manager name)** gan ddefnyddio'r manylion cyswllt ar ddechrau'r llythyr hwn. Byddant yn gallu eich cynorthwyo gyda'ch ymholiad.

Yr eiddoch yn gywir,

Dewiswch eitem.

Partneriaeth Cydwasanaethau GIG Cymru (PCGC)
Ar ran Bwrdd Iechyd Prifysgol Aneurin Bevan

Aneurin Bevan University Health Board

Budgetary Control Financial Control Procedure

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

Status: Issue 4
Approved by: Audit Committee
Owner: Director of Finance
Issue date: DRAFT
Review by date: DRAFT
Policy Number: ABUHB/Finance/0241

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1. Introduction

Aneurin Bevan University Health Board has a statutory requirement to meet its financial duty as set out in in section 175 of the National Health Service (Wales) Act 2006 as amended by the National Health Service Finance (Wales) Act 2014. That is the Board has to provide its services within its allocated resources. One of the key mechanisms for ensuring that this requirement is met is a sound system of budgetary control.

2. Policy Statement

The Health Board must meet its statutory financial duties and this procedure therefore sets out the key mechanisms by which the Board can deliver its financial duty.

2.1 Integrated Medium Term Plan (IMTP)

The NHS Finance (Wales) Act 2014 requires Health Boards to prepare a plan which sets out its strategy for securing that it will comply with the financial duty. The Integrated Medium Term Plan is therefore a statutory requirement and must show how the Board will meets is statutory duty to provide services within the allocated resources measured on a 3 year rolling basis.

The Chief Executive has overall executive responsibility for the LHB's activities and is responsible to the Board for ensuring that it meets its financial duty as set out in section 175 of the National Health Service (Wales) Act 2006 as amended by the National Health Service Finance (Wales) Act 2014.

The Integrated Medium Term Plan (IMTP) therefore provides the foundation for the financial year by expressing the service, workforce and financial plan for year 1 of the three year plan and forms the basis of the Budget for the year.

The IMTP must reflect the Welsh Governments' vision for the NHS in Wales and its standards for public service delivery. The governance standards are based on the Welsh Government's Citizen Centred Governance principles.

2.2 Revenue Resource Limit

The Revenue Resource Limit (RRL) is the allocation of financial resources from Welsh Government (WG) for the financial year. Aneurin Bevan University Health Board has a statutory responsibility to deliver services within its allocated Revenue Resource Limit and three year breakeven duty. Whilst the agreed IMTP may have

planned financial deficits and surpluses in any one year, subject to WG approval, as part of the three year rolling breakeven duty, any planned surplus or deficits will be reflected by Welsh Government in the RRL.

This Policy and Financial Control Procedure sets out how budgetary control processes enable the organisation to meet the statutory duty of meeting its RRL and 3 year breakeven duty.

3. Aims

The aim of this document is to set out the responsibilities of the Board, Chief Executive, Director of Finance, Procurement and Value and budget holders, across the organisation, in relation to budgetary control in order that the organisation can exercise sound financial management and meet its statutory financial duty to break even.

The overall aim of the Budgetary Control Policy and financial control procedure is to enable financial control whilst supporting the achievement of service objectives.

4. Objectives

The Budgetary Control Financial Control Procedure aims to provide a framework for financial control to enable the organisation to meet its statutory financial targets. The objectives are specifically to:

- Describe how the organisation's Budget is approved based in turn on the first year of the Integrated Medium Term Plan which is now a statutory requirement of the Health Board.

- How budgets are formally delegated through the organisation following approval by the Board.

- To set out budget holders responsibilities and accountability to deliver services within the allocated budget.

- To set out a defined process that is to be followed by budget holders if budget overspends arise.

5. Scope

The Board delegates responsibility for budgets to the Chief Executive who in turn delegates these through management structures. Whilst the document primarily applies to all managers and clinicians that are

given financial responsibilities as part of their roles and job descriptions, all staff of the Health Board have a part to play in effective budgetary control.

6. Roles and Responsibilities

6.1 The Board

The Board is responsible for ensuring that it meets its financial duty as set out in section 175 of the National Health Service (Wales) Act 2006 as amended by the National Health Service Finance (Wales) Act 2014.

The Board is responsible for exercising financial supervision and control through approving the Integrated Medium Term Financial Plan and Budget for the organisation.

6.2 Chief Executive

The Chief Executive has overall executive responsibility for the LHB's activities and is responsible to the Board for ensuring that it meets its statutory financial duty.

The Chief Executive has responsibility for initiating a formal process of budget delegation following approval of the Budget by the Board.

6.3 Director of Finance, Procurement and Value

Prior to the start of the financial year the Director of Finance, Procurement and Value will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board.

The Director of Finance, Procurement and Value will devise and maintain systems of budgetary control.

The Director of Finance, Procurement and Value will ensure sufficient records are maintained and accurate.

The Director of Finance, Procurement and Value will report the financial position to the Board.

The Director of Finance, Procurement and Value will ensure that appropriate training is available for budget holders

6.4 Director of Workforce and Organisational Development (OD)

Effective financial management is a key personal objective for budget holders, therefore the Director of Workforce and OD will set up appropriate systems to ensure competencies are met and recorded within job descriptions across the organisation.

6.5 Director of Planning, Digital and IT

The Director of Planning, Digital and IT will ensure that processes are in place to develop the draft IMTP for Board approval within prescribed Welsh Government deadlines.

6.6 Budget Holders

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

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

Specific responsibilities of budget holders are:

- Budget holders are responsible for providing services within their respective budget
- Budget holders are responsible for monitoring monthly budgets, actuals and variance utilising the Finance Business Intelligence Tool (FBI) and liaising with the Business Partner Finance Teams as necessary.
- Budget holders must not exceed the budgetary total or virement limits set by the Board
- Budgets must only be used for the purposes designated, and any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive

- Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance, Procurement and Value
- All budget holders must provide information as required by the Director of Finance, Procurement and Value to enable budgets to be compiled and managed appropriately.
- To not incur any overspend or reduction of income without the prior consent of the Chief Executive subject to the Board's scheme of delegation
- No permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and workforce establishment as approved by the Board
- Develop recovery plans to address adverse budget variances
- Budget holders should keep a record of any recovery plan meetings with line managers and/or Division as appropriate.

7. Main Procedure

7.1 Budgets

A budget is a plan expressed in financial terms, over a defined period of time. In the context of the University Health Board, the plan is for the delivery of specific services and should represent the financial expression of service and workforce plans for the financial year within available resources. The Board approve the Budget for the year.

This financial control procedure for budgetary control represents a key corporate objective for the organisation. Budgetary control is delegated to managers and represents a key management objective. Therefore, it represents a significant element of a manager's responsibility and budgetary performance must form a key part of each manager's Performance Appraisal Development Review (PADR).

7.2 Approval of the IMTP Prior to the New Financial Year

It is a statutory requirement to produce an IMTP that must be approved by the Board prior to the start of the financial year. The IMTP plan will express service and workforce plans for the organisation over a period of three years and include a Medium Term Financial Plan that is derived from those plans.

The Board will:

- Approve the Integrated Medium Term Plan prior to the beginning of the financial year of implementation. Following Board approval the IMTP will be submitted to Welsh Government prior to the beginning of the financial year of implementation.

- Approve a balanced Medium Term Financial Plan as part of the Integrated Medium Term Plan, which meets all probity and value for money requirements; and

- Where the LHB plan is not in place or in balance, prepare and agree with the Welsh Government a robust and sustainable recovery plan in accordance with Welsh Ministers' guidance.

7.3 Budget for the Year

The organisation's budget plan for the forthcoming year will be developed from the first year of the Board's Integrated Medium Term Plan (IMTP). The corporate processes that develop the IMTP will ensure that service and workforce plans are developed, within the financial Revenue Resource Limit, and agreed by the organisation before the beginning of the financial year and are at a sufficient level of detail that enable budgets to be developed for the year.

The Executive Director with the lead for Planning will ensure that processes are in place to produce:

- A draft IMTP (within Welsh Government timescales), which will have sufficient detail within year 1 of the plan to enable the development of budgets for the forthcoming year financial year.

- A final IMTP is produced (within Welsh Government timescales) prior to the forthcoming financial year.

Prior to the start of the financial year the Director of Finance, Procurement and Value will, on behalf of the Chief Executive, prepare and submit budgets for approval and delegation by the Board. Such budgets will:

- Be in accordance with the aims and objectives set out in the Integrated Medium Term Plan and Medium Term Financial Plan, and focussed on delivery of safe quality patient centred quality services

- Accord with Commissioning, Activity, Service, Quality, Performance, Capital and Workforce plans;

- Be produced following discussion with appropriate budget holders;

- Be prepared within the limits of available funds;

- Take account of ring-fenced or specified funding allocations;

- Take account of the principles of sustainable development; and

- Identify potential risks.

The plan will make explicit assumptions about budget reserves and contingencies for the year.

7.4 Delegation and Accountability

The Health Board has a statutory duty to manage its services within the Revenue Resource Limit allocated from Welsh Government (WG). The Board delegates responsibility for delivering a balanced budget to the Chief Executive, within the framework of its Standing Orders and Standing Financial Instructions.

The Chief Executive may delegate the management of a budget or part of a budget to permit the performance of a defined range of activities. This delegation is made through management structures and defined in job descriptions and annual objectives. The delegation will cover:-

- the amount of the budget;
- the purpose(s) of the budget
- the requirement to achieve a balanced budget
- achievement of planned levels of service

Except where otherwise approved by the Chief Executive, taking account of advice of the Finance Director, budgets shall be used only for the purpose for which they were provided.

Budgets are delegated with assumptions about the levels of service to be provided within the available resources described by the budget. Budget holders do not have authority to commit resources to beyond the resources delegated in the budget. Expenditure for which no provision has been made in an approved budget, or is not subject to funding under the delegated powers of virements, shall only be incurred after authorisation of the Chief Executive.

Non-recurring funding must not be used to finance recurring expenditure without the authority in writing of the Chief Executive or nominated deputy for the purposes of financial control.

Managers must deliver a balanced budget within each and every financial year.

The key principle of delegation is that accountability for budgetary control is exercised through the line management hierarchy. Budgets are therefore formally delegated through the management hierarchy. Budget holders must not overspend against their budget. The requirement to deliver within the allocated budget must therefore form part of all budget holder's annual objectives and be reviewed as part of the annual review process.

The principles of delegation mean that accountability for budget management is to the line manager. Review of performance against budget should therefore take place as part of the line management PADR process in the context of the wider performance review of quality, safety and other targets. The principles and responsibilities set out in this policy therefore relate to all managers with budgetary responsibility and their line managers.

Budgets are delegated to nominated budget holders and are set for each cost centre. Budget holders are authorised to commit expenditure against the cost centres for which they are responsible. There can only be one nominated budget holder for a cost centre and they are held accountable for managing within the budget set. Budget holders must adhere to approval limits set out in the Aneurin Bevan Health Board 'Scheme of Delegation' and the approval hierarchy must follow the line management hierarchy. These approval limits must not be exceeded but may be restricted by the organisation.

If budget holders are unable to approve expenditure for their respective budgets due to absence then the principle of upward delegation will apply.

7.5 Process of Delegation

Following agreement of the Board to the plans, the Chief Executive will issue a formal budget letter to each director who in turn will issue similar letters to their line managers. This process will be repeated through each tier of management, setting out the expectations and responsibilities in terms of budgetary control and financial management.

The letter content may vary from year to year but will cover:

- The budget allocation.
- Activity and target achievement assumptions on which the budget has been based where this is a material issue. An example would be activity levels and achievement of elective targets such as referral to treatment times (RTT).
- That the budget holder is accountable for the delivery of a balanced budget position each financial year and is also accountable for the recovery of any deficits within the same period.

- That budgetary performance must form part of all budget holders' annual objectives and to be reviewed as part of the annual performance review.

- The expectation that formal mechanisms are set up to ensure that budget management is effective across their management area and that budget holders are held to account for their budgetary performance through every level of line management.

- That all line managers review their direct reports in relation to their budget performance at least on a monthly basis.

- That appropriate mechanisms are set up to control expenditure particularly where there are high cost and variable use items.

- That budget holders comply with policies that aid budgetary control including:

    - All Workforce and Organisational Development policies relating to authorisation of payments to and for staff
    - Vacancy Approval Process
    - Recruitment Procedures
    - Financial Control Procedure – Procurement Policy
    - Financial Control Procedure – Approving Orders Greater than 100k

A formal budget letter must be issued from each line manager as soon as possible following the start of the financial year. An example of a delegation letter is attached in Appendix 1.

7.6 Changes to the Budget

There may be times during the financial year when it is necessary to make adjustments to the budget, for example if additional funding is made available from Welsh Government. As the budget has already been delegated through the Board and Chief Executive, there should be no requirement to refer changes to the Board. However, where there are significant changes to the proposed usage, which are outside of agreed priorities and delegation arrangements, there is an expectation that the Board be notified and potentially approval sought. As part of the monthly control and

reporting process, budgets will be reviewed and significant budget changes identified.

7.7 Budgetary Control and Reporting

The Director of Finance, Procurement and Value will devise and maintain systems of budgetary control. These will include:

- Financial reports to the Board showing performance against budget for the period and a forecast of the outturn for the full financial year.
- Issuing financial reports on a timely basis to budget holders covering the areas for which they are responsible.
- Following the end of a month a report will be produced for the executive team, divisional directors setting out the year to date budget performance.
- Providing support from appropriately qualified and experienced finance staff to support managers in their analysis and management of budget performance.

Budget holders will ensure:

- Accountability for budgetary control is exercised through line management relationships and this principle applies through all tiers of management where budgetary control is applicable.
- Budget performance is discussed by managers and their immediate reports at least on a monthly basis.
- That all significant financial issues are reported through the management hierarchy, to enable the director responsible to report the possible financial impact to executive team and board.

7.8 Performance Management

Aneurin Bevan Health Board has a statutory duty to deliver its services within its allocated budget. The Board via the Chief Executive and tiers of line management formally delegates this responsibility to individual budget holders across the organisation. Budget holders are held to account for budgetary performance through formal line management arrangements and are expected to manage within

delegated resources on both a monthly and annual basis. This requirement links to the Health Board's statutory requirement to manage within its Revenue Resource Limit.
Where budget variances arise the following actions must be undertaken by the budget holder and line manager in a formal process of escalation:

- If a budget is overspent in any one month the budget holder where practicable will recover the position by the next reported period.

- If a deficit will take longer than one month to correct and recover then the budget holder and line manager will:

  Either
  - agree recovery actions over a defined period

  Or
  - agree virements from another area of budgetary responsibility

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

- If a deficit cannot be recovered within a period of 3 months, or virements agreed with the budget holder, the line manager will be required to agree remedial actions with the Divisional Director.

- If remedial actions to recover the deficit, or agree virements still cannot be agreed with the Divisional Director, the line management team will agree remedial actions or virements with the responsible Executive Director.

- If remedial actions to recover the deficit, or agree virements, still cannot be agreed with the Executive Director, the Chief Executive will agree remedial actions or virements.

- If there is continued failure to agree a recovery plan or virements, the Executive Director and Chief Executive will agree remedial actions with the Audit Committee and Board.

- A record of the meeting to discuss and agree recovery

actions must made. A suggested proforma is attached in Appendix 2 to record agreed actions.

Budgetary control must form a key objective each year for all management staff with budget responsibilities.

Managers will be held to account for not meeting budgetary targets and subject to formal review as part of their wider performance management review with their line manager.

7.9 Virements

Where budget funding is transferred between budget holders, known as a virement, a form must be completed to formally record the agreement and transfer of funds. A form is attached in Appendix 3.

The virement or allocation of central budget reserves should be formally notified to the Board as appropriate through the financial year.

8. Training

The Finance Director will ensure that Financial and Budget training is available, as part of the staff induction process.

This will include training provided by one-to-one contact with finance department staff, formal financial management training, briefings, and finance content within other management development programmes.

Finance Business Intelligence is also provided and budget holders are encouraged to attend. Non attendance reports are provided to line managers and BPA teams to follow up.

9. Review

This policy and financial control procedure must be reviewed, maintained and developed periodically, in line with the Health Board's policy. Responsibility for this lies with the Chief Executive and Finance Director.

10. Audit

This document is a key organisational policy and as such will be subject to regular internal audit reviews to ensure the system is working effectively and that the processes set out in the policy and financial control procedure are being complied with across the organisation.

APPENDIX 1 - Example of Budget Delegation Letter.

The content may change from year to year, in line with the Health Boards plans and priorities.

Our Ref: NW/RH/ **Direct Line**: XXth March 20XX

Dr xxxx
Divisional Director – xxx
Aneurin Bevan University Health Board
Royal Gwent Hospital
Cardiff Road
Newport
NP20 2UB

Dear xxx,

RE: DELEGATION OF BUDGETS FOR THE 20XX-XX FINANCIAL YEAR

As you will be aware, the Health Board has a statutory obligation to perform its functions within available financial resources. In line with the Board's Standing Financial Instructions (SFI) and Budgetary Control Policy, I am formally writing to you to confirm the revenue budget delegated to you for the 20XX-XX financial year – this is set out in Table 1. Achieving your budget responsibilities is one of your key performance objectives and will be reviewed as part of your Performance Appraisal and Development Review (PADR).

Table 1: Delegated Annual Revenue Budget 20XX-XX financial year

Budget Area	Annual Revenue Budget £'000
Xxxx	xxxx

The annual budget shown above includes provision for:

- Agenda for Change and Medical pay awards
- Funding to support additional (£xxxk)
- Funding to support NICE demand and service growth (£xxxk)

The additional funding delegated is subject to review and evaluation of schemes. This is in order to provide assurance that the investment is achieving the necessary organisational performance targets.

This letter provides formal authorisation for you to incur expenditure during the financial year, up to the annual budget, to perform the functions necessary to deliver the Health Board's priorities and objectives. It also clarifies your accountability to deliver services within the budget and not to overspend.

You should manage your budgets in line with the Health Board's Budgetary Control Policy which is available on the intranet and sets out, in detail, budget holder's responsibilities and actions that should take place, if budget overspends arise. This letter should be read in conjunction with the Health Board's Standing Orders (SO), Standing Financial Instructions (SFI), financial policies and procedures – specifically, the Financial Control Procedure on Budgetary Control and the scheme of delegation.

Budgetary Management
The formal delegation of the budget should be cascaded through all tiers of line management responsible for budget management, with budgetary performance reviews undertaken and appropriate actions taken. It is important that all budget holders have read and understood the SFIs and financial control procedures and are competent to manage a budget. Therefore, all budget holders are required to confirm this as part of accepting their budget responsibilities.

Additional Allocations
The budget delegated to you is in line with the financial plan agreed by the Board on the XXrd January 20XX. Further allocations will be made in year as required to reflect additional allocations from Welsh Government, allocation of the agreed provisions within the financial plan and any investment priorities or choices made by the Executive Team and Board in 20XX/XX.

In approving a balanced financial plan for 20XX/XX, the Board recognised that further detailed plans need to be finalised. Funding has been held in reserve pending the completion of these plans and may be allocated subject to satisfactory approval of these plans. This will need to include delivery of key performance targets and appropriate savings. These should be completed and forwarded to myself by the **XXth April 20XX**.

IMTP
The Health Board has submitted its outline IMTP to Welsh Government which whilst demonstrating a balanced financial position carries a high level of financial risk. It is therefore important that every budget holder delivers within their delegated budgets. The expectation is that the department will develop plans to deliver a break-even financial position within this funding envelope.

Financial Advice and Information
Your Business Partner Team are available to offer guidance and training for you and your team as required to facilitate understanding and managing your budget and the FBI (Finance Business Intelligence) reporting tool.

As part of supporting budget holders to competently manage their budgets, the Health Board requires all budget holders to successfully complete appropriate budget training. Further training opportunities will also be made available in year as part of the finance departments training programme for non-finance managers.

Please confirm your acceptance of the delegated budget by signing and returning Appendix 1 to me by **XXth April 20XX.**

Yours sincerely,

XXX
Executive Director of Operations, Corporate Services

CC XXX, Assistant Finance Director - Financial Planning & Performance
XXX, Assistant Finance Director - Hospital Services
BPA xxx

Acceptance of delegated budget for the 20XX-XX financial year

To: Divisional Director –

I am signing to confirm acceptance of the budget delegated to me, for the purposes outlined, in your letter dated XXth March 20XX. I can also confirm that I have read and understood the Health Board's Standing Orders (SOs), Standing Financial Instructions (SFIs) and financial control procedures and policies and that I have undertaken the necessary training to competently manage a budget.

NAME:	**SIGNATURE:**
POST TITLE:	
DATE:	

APPENDIX 2 - Template for Line Manager/Budget Holder Recovery Meeting

ABUHB BUDGETARY CONTROL POLICY

Record of Line Manager/Budget Holder Meeting to Agree Budget Overspend Recovery Actions

1. Attendees

List of Staff Attending Recovery Meeting	Position
Date of Meeting:	

2. Agreed Actions to Recover Budget Overspend

List Actions	Effective Date

3. Agreement

Delegated Budget Holder	Date
Line Manager Signature	**Date**

APPENDIX 3 – Virement Form
ABUHB BUDGETARY CONTROL POLICY
VIREMENT FORM

1. Reason for the Virement (Budget Transfer)

Description of Service or Rationale for Transfer	WTE	£
Budget Transfer Timescale i.e. Non recurrent, Recurrent or Time limited		

2. Transfer Agreement

Budget Holder Transferring Funds	Budget Holder Receiving Funds
Name:	**Name:**
Position:	**Position:**
Budget Cost Centre and Subjective code:	**Budget Cost Centre and Subjective code:**
Signed:	**Signed:**
Date:	**Date:**

3. For Finance Use

Oracle Account Code				£ Dr	£ Cr	
CC	**Subj**	**Analysis**				
Actioned By:						
Name:						
Signed:						
Date:			**Ledger Mth/Yr**			

Archwilio Cymru
Audit Wales

Assure, Explain, Inspire

Our strategy 2022-27

A time of challenge and opportunity

After a long period of austerity and the economic hit from the pandemic, the coming years will offer little respite for the already stretched public finances in Wales.

The pandemic has posed enormous challenges but demonstrated great strengths in our public services. The opportunity now is to build on the progress made in transforming the way services are provided to tackle the long-standing challenges that have pre-occupied the Welsh public sector for some time.

Despite these changing times, our purpose at Audit Wales remains constant – to assure people that public money is being managed well, to explain how that money is being spent and to inspire the Welsh public sector to improve.

That is why the timing and focus of this strategy are so important. Through its development we have challenged ourselves as an organisation, sought the scrutiny of others and gained a wealth of insight to help us identify a clear direction and focus for the next five years.

Many of the challenges we face in Wales today – in areas such as inequality, public health, and the climate emergency – are complex, interconnected and span the remits of a range of organisations. Our audit focus will evolve to reflect that complexity and how services are organising themselves to respond to the challenges we face.

We intend to place a greater emphasis on thematic reporting, comparisons across audited bodies and the identification and sharing of good practice. We will build greater flexibility into the design and delivery of our work programme to respond to emerging issues and invest in our research and development capacity and capability.

The single biggest area of our work supports the delivery of the Auditor General's annual opinions on financial statements. In the coming years we plan to develop a range of outputs that make greater use of this wealth of intelligence.

To achieve our vision, it is vital that our work is impactful and that our messages hit home. This relies heavily on the effective relationships we have with our audited bodies. We will seek to engage new audiences while creating more engaging, timely and topical audit products and sharper, bolder messaging.

Perhaps most importantly, we are committed to ensuring Audit Wales is a model organisation for the Welsh public sector, one that recognises and values our people within a culture that allows everyone to thrive. Our commitment to challenging inequality is embedded in our work and we will always challenge ourselves to do more. We are proud to be a bilingual organisation and continue to embrace the Welsh language in our activities.

The sustainable development principle and the 'five ways of working' set out in the Well-being of Future Generations Act are key to our work. We will also grasp the opportunity to be a digitally mature, data driven organisation, while proactively managing the risks of cyber security.

Like all public sector organisations, we face financial challenges and will take a strategic approach to align our medium-term financial position, our service provision and the shape of our workforce.

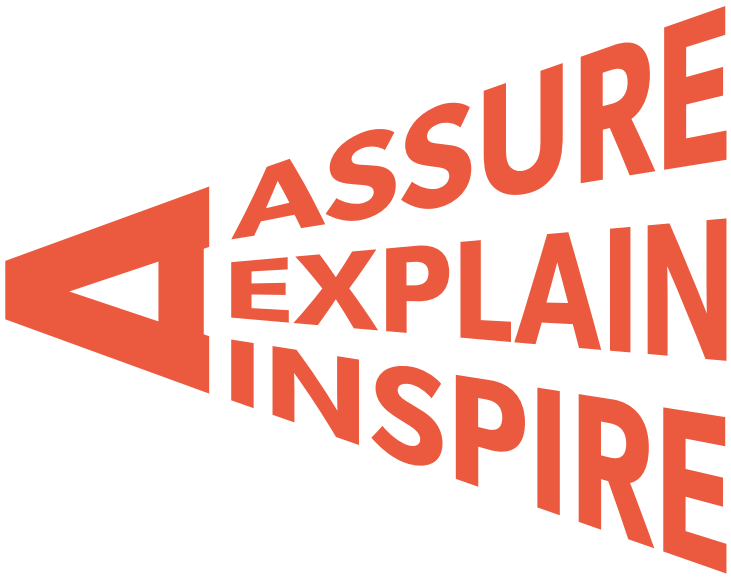
The pandemic has posed personal and professional challenges for us all. We are indebted to all Audit Wales staff and thank them for their professionalism, hard work and commitment to public service through these challenging times.

Adrian Crompton
Auditor General for Wales

Lindsay Foyster
Chair,
Wales Audit Office

Our purpose and vision

Our purpose is at the heart of everything we do in Audit Wales. However, we recognise that the way in which we deliver this will evolve to reflect the significant challenges facing public services.



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

Strategic, dynamic, high quality audit programme

Targeted and impactful approach to communications and influencing

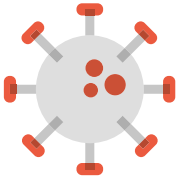
Culture and operating model that allows us to thrive now and in the future

Emerging trends

Our work programme will be shaped by three trends identified in our Picture of Public Services analysis:

A changing world

- Climate change: achieving a fair and just transition
- Equalities: responding to demands for a fairer and more equal society
- Constitution: managing the opportunities and risks of new relationships within the UK



The ongoing pandemic

- Direct costs of response
- Economic hit knocks-on to public finances
- Legacy costs of long-term impacts

Transforming service delivery

- Systems and culture to support new approaches to service delivery
- Purposeful collaboration
- Long-term planning and prevention
- Harnessing technology where appropriate
- Using data to learn across the whole system

This analysis will be refreshed continually to ensure they remain relevant.

A Wales perspective

Our strategy does not sit in isolation from the wider Welsh public sector landscape.

We will apply the lens of the Wellbeing of Future Generations Act to all our thinking and decision making.

Our ambitions for Audit Wales to become a modern, forward focused model organisation for Wales will ensure that our strategic drivers around future workplaces, our digital vision, workforce and financial plans and net-zero ambitions are interconnected – creating a strategic eco-system that creates synergies and value across the organisation and the wider public sector.

How we got here

The development of this strategy has been informed by the Wales Audit Office board, executive leadership team and staff. We have engaged with key stakeholders to test and refine our thinking.

Our assessment of progress against our four ambitions has identified areas of strength and those we want to improve.

Fully exploit our unique perspective, expertise and depth of insight

Where we are

- We have integrated teamwork and outputs.
- We have specialist teams and expertise.
- We are evolving our use of technology.
- We share knowledge.
- We have a depth of knowledge and insight.

Where we want to be

- We have integrated cross-organisational and sectoral teams, supported by better resource management.
- We have staff working across a range of projects and activities.
- Using technology to enable seamless sharing of knowledge and past work.
- Working in the open with greater transparency and visibility of our work.

Strengthen our position as an authoritative, trusted and independent voice

Where we are

- We produce high-quality, evidence-based reports.
- When our work hits the target, it is well referenced by our stakeholders.
- Build on our pace of publishing to deliver work on 'the right issues at the right time'.
- Stakeholders attribute value to national and local work but some differentiate between the two.
- Our accounts work is trusted and delivered on time, and we are seen as experts in the field.

Where we want to be

- We are at the forefront of thinking and are a trusted commentator of choice.
- We can identify and draw on a wide sphere of expert knowledge and innovative practice.
- We have bold, clear messages and do not shy away from delivering tough messages.
- We horizon scan and proactively pick up emerging topics where we can engage using existing reports or work in progress.

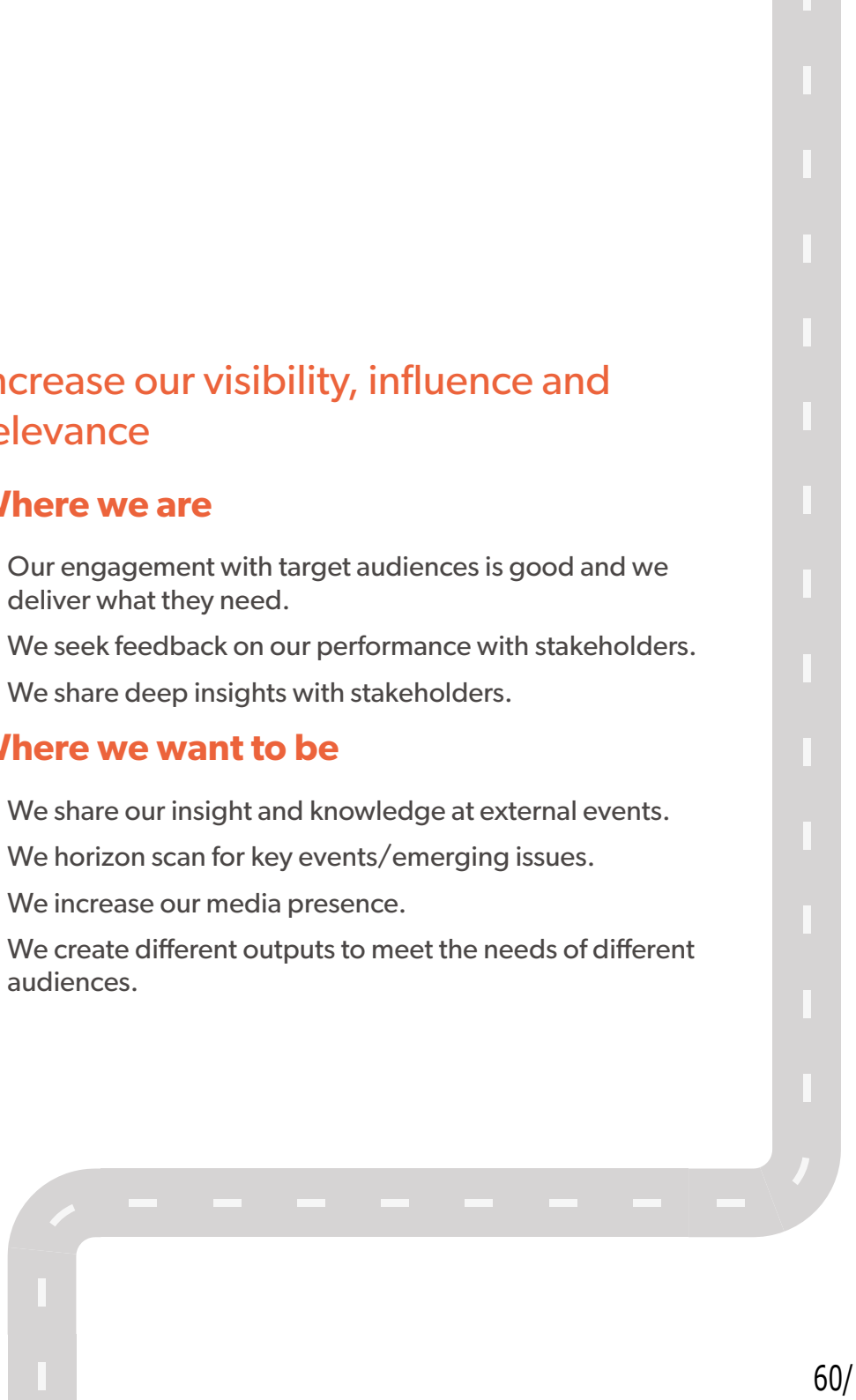
Increase our visibility, influence and relevance

Where we are

- Our engagement with target audiences is good and we deliver what they need.
- We seek feedback on our performance with stakeholders.
- We share deep insights with stakeholders.

Where we want to be

- We share our insight and knowledge at external events.
- We horizon scan for key events/emerging issues.
- We increase our media presence.
- We create different outputs to meet the needs of different audiences.



Be a model organisation for the public sector in Wales and beyond

Where we are

- We have strong processes that ensure good governance, risk management and control of resources.
- Our senior leaders take time to consider complex decisions.
- We have evolving performance management arrangements.
- We are removing legacy cultural and structural barriers.
- We promote equalities.

Where we want to be

- Building our reputation as a forward focused and innovative modern organisation.
- Embedding the sustainable development principle into how we do business.
- Deploying resources to maximise economy, efficiency and effectiveness, informed by thorough and robust data and management information.
- Our managers are drivers of change, providing strong and united leadership across the organisation.
- We are forward-looking, developing skills and capabilities to meet business need.

One Audit Wales

Our reputation and impact depend upon the quality of work we deliver and everyone in Audit Wales has a part to play. Central to the success of this strategy is a relentless focus on ensuring the quality of our audit work and effectiveness of our internal operation in the following ways:

- We have the right people, doing the right things with the right skills.
- We invest in technology and skills.
- Our staff are clear about our direction of travel and their role in achieving our ambitions.
- Our leaders create the conditions for people to thrive and engage.
- Our people have the best possible development and ways of working to deliver high quality audit work and grow in their roles.
- Employee interactions maximise individual and team performance.
- We respond to feedback and have a culture of continuous improvement.
- Our change activities are anchored in improving quality and impact.

What our stakeholders told us

What we said about our strategy

Strategic, dynamic and high-quality audit programme

- This will require us to set out our programme in a different way, emphasising it is more flexible than in the past.
- Form dynamic development groups drawn from those with experience and knowledge.
- A visible programme of work seems to be a 'should have' rather than a 'nice to have'.

Targeted and impactful approach to communications and influencing

- Aiming to ignite light bulbs and empower audited bodies to think and draw up solutions as we go is key to impact.
- We need to consider the differing audiences and ensure that communication matches their needs.
- Invest in finding out who our audiences are, and what they want to hear from us.

Culture and operating model that allows us to thrive both now and, in the future

- Make timelines visible. Show where challenges happen and make pace a priority.
- Effective feedback can only strengthen our leadership capabilities.

> **"It is so important to follow where the money has gone and what difference it has made"**

What our external stakeholders said

- I like the thematic approach – focusing on the right topics delivering outcomes for citizens.
- It is so important to follow where the money has gone and what difference it has made.
- Look at how organisations work with people to prevent complex issues.
- Focus on good practice from outside of Wales. It is time to be radical.
- Work across sectoral silos, reflect the impact of collaboration and partnership working.
- If things go wrong, we need to know.
- Maximise the insights from the accounts programme.
- Create opportunities for greater collaboration.

Our focus for the next five years – themes and outcomes

We have identified three areas of focus where we will prioritise action to achieve our ambitions, alongside the delivery of our core statutory responsibilities.

- Strategic, dynamic and high-quality audit programme.
- Targeted and impactful approach to communications and influencing.
- Culture and operating model that enables us to thrive both now and in the future.

Strategic, dynamic and high-quality audit programme

We will....

Strike the right balance in having a bank of pre-planned audit projects and sufficient flexibility to respond to emerging areas of interest.	Establish research capability and capacity and use it to shape our audit programme.	Take a more holistic approach to audit delivery, that draws on expertise and knowledge from across the organisation.
Establish a rigorous and transparent process for managing our local and national audit programmes.	Make more use of relevant previous work when responding to emerging areas of interest.	Drive continuous improvement in the quality of our work through the application of all relevant international auditing standards.

Our measures of success

- Statutory deadlines: proportion of audit products delivered by the required statutory deadline.
- On time: proportion of other key audit products delivered in accordance with the planned timetable for ensuring timely and impactful reporting.
- Quality: proportion of reviewed audits that are delivered in accordance with Financial Reporting Council (FRC) quality standards.
- Credibility: proportion of stakeholders that consider us to be an independent and authoritative communicator on the governance and stewardship of public money and assets.
- Providing insight: proportion of stakeholders who said that through our work, they gained useful insight that they would not have acquired otherwise.
- Driving improvement: proportion of stakeholders who believe our work has led to improvements in the provision of public services.
- Savings identified: value of potential savings, income, productivity gains and other financial benefits identified through our work.

Targeted and impactful approach to communications and influencing

We will....

Adopt a campaign-style approach to external communication, built in from the start of projects.	Sharpen our messaging and presentation and strengthen our digital presence.	Proactively identify opportunities to showcase our work and repurpose our outputs accordingly.
Equip staff to better exploit opportunities to influence a wide range of audiences.	Take a more prominent role in shaping the future of public audit.	

Our measures of success

- Proportion of stakeholders who rate our good practice events useful or very useful.
- Number of visits to our website where at least one action is performed, eg download a report, click on a video.
- Number of social media engagements, ie interactions with our posts such as a like, a comment, or retweet/share.
- Number of instances where we present audit learning to key policy working groups or at relevant externally hosted events.

Culture and operating model that allows us to thrive both now and, in the future

We will....

Embed a culture where everyone feels they have a voice and are valued, and where successes are widely celebrated.	Increase opportunities for collaboration, innovation and the sharing of ideas.	Ensure our ways of working lead to quick and effective decision making that is open and transparent.
Develop our workforce for the future through agile performance and talent management arrangements.	Strengthen leadership capabilities across the organisation.	Work in a smart and sustainable way where we maximise the potential of our people and physical assets.

Our measures of success

- Positive staff engagement and employee experience scores in our People Survey.
- Reduced sickness absence.
- Level of variance from our estimate.
- Value of cost savings and efficiencies.
- Reduced CO_2 emissions.
- Trainees achieving first-time passes in their professional exams.

Archwilio Cymru
Audit Wales

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www.audit.wales / www.archwilio.cymru

Mr Mark Isherwood MS
Committee Chair
Public Accounts and Public Administration

Sent via email to:
SeneddPAPA@senedd.wales

Reference: AC/309/caf
Date issued: 1 July 2022

Dear Mark

The Welsh Community Care Information System

I published my report on the Welsh Community Care Information System (WCCIS) in October 2020. WCCIS has been developed as a single system and a shared electronic record for use across a wide range of adult and children's services. The intention being that all 22 local authorities and seven health boards would implement it.

My report found that implementation and roll-out of WCCIS was taking much longer and proving more costly than expected. Despite efforts to accelerate the process, the prospects for full take-up and benefits realisation remained uncertain. Some important issues around the functionality of the system, data standards and benefits reporting were still to be fully resolved.

At the time of my report, 19 organisations were using WCCIS or had signed deployment orders, with four in active negotiation and six yet to commit. Of the 19 organisations, 13 local authorities and two health boards had gone live. However, 'live' meant different things. Differences in how organisations were choosing to deploy WCCIS limited opportunities for integrated working and raised other value for money issues.

I noted in my report that the potential benefits of a shared electronic record across health and social care were clear to see; even more so given some of the challenges presented by the COVID-19 pandemic. However, the Welsh Government's ambitious vision for WCCIS was still a long way from being realised. I emphasised that the

Welsh Government needed to work with the various organisations involved to take stock of expectations for the remainder of the contract term and resources and wider commitment to support progress.

The previous Public Accounts Committee (PAC) did not have time to undertake any detailed inquiry work on WCCIS. However, the Welsh Government provided a response to my recommendations, all of which were accepted as part of correspondence with the PAC in February 2021. The PAC had requested a wider update on matters arising from its November 2018 report on Informatics Systems in NHS Wales and my predecessor's January 2018 report on the same topic.

Since my report, the functions previously undertaken by the NHS Wales Informatics Service (NWIS) have moved from its previous structure, as part of Velindre University NHS Trust, to the new 'Special Health Authority' – Digital Health and Care Wales (DHCW). DHCW plays a key role in national programme management for WCCIS, although since my report staff turnover has seen two changes in previous temporary appointments to the role of WCCIS programme director. From early 2022, the role of WCCIS programme director has become a permanent position.

The WCCIS programme is now at a critical juncture. The Welsh Government has taken several actions in response to my recommendations, most notably an independent 'Strategic Review' which reported in February 2022. The review found that while support for the vision of an integrated health and social care system remained, there was also widespread frustration.

Many of the issues highlighted by my report were mirrored in the Strategic Review findings. The Strategic Review has recommended a series of actions to 'reset' and 'course correct' the programme. The Welsh Government has also recently announced further funding for national programme management to take this work forward. It will also provide further financial support to health boards and local authorities to support implementation.

The Annex to this letter provides a more detailed update on the main actions so far in response to my recommendations and on progress generally against key issues raised by my report. By way of summary:

- Relevant to my specific recommendations, the Welsh Government commissioned research to gather views from users and others about the performance and functionality of the system. The survey findings in June 2021 highlighted the system was having a more negative than positive impact on most users' ability to do their work. Preceding the Strategic Review mentioned above, there was also a programme assurance review which concluded in November 2021 and a further one scheduled for November 2022. DHCW also completed an exercise to learn lessons from the contracting approach for WCCIS.

- Ongoing rollout has seen two more local authorities ‘go live’ with the system since my report while one further health board has now signed a ‘deployment order’. However, it remains the case that patchwork approaches to implementation mean that even where the system is live, it is not being used to its full potential or on a consistent basis. We have updated our interactive data tool which provides further detail on the overall roll-out position across the 29 organisations.
- Central support costs for the period to 31 March 2022 – excluding local costs to individual organisations and other opportunity costs – remain at around the £30 million expected at the time of my report, although the profile of those costs has changed. The Welsh Government has now committed a further £8.31 million for national programme support and support for health board and local authorities in accelerating implementation for 2022-23 to 2024-25. The Welsh Government has agreed that this figure may increase to up to £12 million if required. The overall business case for WCCIS has not yet been updated, something that I recommended should happen in advance of committing more funding. The Strategic Review has also now recommended that the business case be updated.
- Key aspects of functionality continue to be delayed. Areas where work continues to be needed include Welsh-language requirements, mobile functionality and interfaces with other NHS Wales systems. As of June 2022, all these areas of functionality remain outstanding although mobile functionality is due to be piloted later this calendar year and most of the interfaces are also now expected by the end of 2022. When I reported previously, it had been estimated that the remaining updates would be delivered through to the end of 2021.
- System performance issues became particularly acute during Autumn 2021 but overall system performance has since stabilised. Several organisations have identified specific risks to service delivery around the stability of the system at different points. Significant performance issues during a planned upgrade to the underlying platform for the system resulted in the system being unavailable altogether for certain periods during October and November 2021. These issues continued to some extent into early 2022 before being resolved in February 2022. Since this time, both the system suppliers and the National Programme Team have reported the system performance and stability has been good.
- National data standards work has continued but is still not complete. Development of these standards is key to realising some of the benefits of WCCIS.

- The overall arrangements for reporting the benefits from WCCIS implementation, which have been the subject of discussion and review from the outset, have still not been resolved. Work is still ongoing to develop a suitable reporting framework. Annual reporting on the progress of the WCCIS programme has also not been completed as expected to date, although the Welsh Government has been receiving quarterly updates from the National Programme Team. The National Programme Team produced a benefits realisation report in November 2021, although its key findings largely mirrored my own, that the 'patchwork' nature of implementation has resulted in difficulties realising some of the key information sharing and integrated benefits that the system was expected to support.

Following considerable diagnosis of the difficulties that have affected the WCCIS programme, strong leadership is now required to ensure value for money from the £30 million investment to date and future spending and to determine the overall future of the programme in partnership with those organisations currently using the system and those who are not. As part of this, a decision will be needed on the future contracting strategy and whether to retain the commitment to a single system solution or allow for different 'interoperable' systems using the same standards and ensure the development of those standards moves at a quicker pace than it has to date.

Time is now of the essence, with the strategic review identifying that at least two local authorities that had signed deployment orders have been reviewing whether to stay with the current system and some key contractual milestones not far ahead. There is added complexity from the fact that those organisations currently using the system have moved to it at different times, meaning their deployment orders will also expire at different times. My report set out details about the contractual framework. This included a Master Services Agreement (MSA), which expires in March 2023, but can be extended on a 1+1+1+1 basis until March 2027. Local deployment orders may run beyond March 2027 but must end by March 2030. Again, these deployment orders include opportunity for extension on a 1+1+1+1 basis but the first deployment order, signed by Bridgend County Borough Council, comes to the end of its initial 8-year period at the same as the MSA in March 2023.

The National Programme Team has pointed to various factors that have impacted on overall progress of the WCCIS programme since my report. These have included the ongoing impact of the pandemic, the transition from NWIS to DHCW and the significant attention that needed to be given to addressing performance issues that emerged in Autumn 2021. However, they have also emphasised their view that with stability to the system and clearer direction following the Strategic Review, the programme is in a better place to progress other key actions.

The Committee has signalled interest in returning to consider wider issues around digital health and care in the autumn. Any such scrutiny would provide an opportunity to explore matters arising from this letter and my previous report in more detail.

Yours sincerely

ADRIAN CROMPTON
Auditor General for Wales

Annex:

My previous recommendations and action taken in response

1 In my October 2020 report I recommended that:

- Before committing any further central funding, the Welsh Government works with the WCCIS National Programme Team, health boards, local authorities and the supplier to:
  - produce an updated business case that takes account of local, regional and national costs and sets out expectations for further roll-out of the system, its use over the remainder of the contract term, the development of national data standards and planning for any successor arrangements;
  - ensure the organisations involved have the necessary capacity to support implementation and are giving enough priority to the programme against a clearly agreed plan; and
  - pull together a clear national picture on feedback from front-line users about the performance and general functionality of the system.
- The Welsh Government works with the National Programme Team to consider:
  - how the WCCIS contract might have been strengthened to support and incentivise delivery and manage risk; and
  - how relevant lessons can be applied to any successor contracting arrangements and wider public procurement.

2 The Welsh Government accepted the recommendations. Progress towards addressing them has included a programme assurance review which concluded in November 2021. There has also been a 'Strategic Review' carried out by external independent consultants. The consultants began their work in November 2021 and produced their final report in February 2022. The Strategic Review raised

several recommendations, all of which have been accepted by the Senior Responsible Officers (SROs) for the programme[1].

3 The Welsh Government also commissioned independent researchers to carry out surveys and workshops with users and non-users of the system in June 2021. The purpose was to gather genuine and independently assessed views of the performance and functionality of the system.

4 Meanwhile, DHCW completed an internal Lessons Learned review in October 2021 that considered how the WCCIS contracting framework could have been strengthened.

5 An updated business case for WCCIS has not yet been produced but the Welsh Government has nevertheless committed some further central funding. The Strategic Review has also now recommended that the business case be updated. The National Programme Team has noted that further work is now needed following the Strategic Review to set out the technical and commercial strategy and associated costs and benefits to inform a revision of the business case.

6 The remainder of this update provides further detail about the actions set out above.

General update on progress since my report

Strategy and contracting

DHCW Lessons Learned review – the WCCIS contracting framework

7 The key lessons learned identified by DHCW's review were:

- a phased approach should have been built into the contract at the outset as a default aspect for health boards to allow them flexibility for them to implement at their own pace.
- a clear plan should have set out the approach to service and contract management arrangements during the procurement

[1] The SROs are the Chief Executive of Powys Teaching Health Board and the Director of Social Services and Housing at Caerphilly County Borough Council.

along with a review process built in. This would have ensured roles and responsibilities were clearly understood across the programme.

- national standards could have been agreed at the contract specification stage.
- all organisations with contractual obligations should have had access to the contractual agreement and documentation.
- an overview of the contract and training should have been provided to all key stakeholders so that the key terms, obligations and relationships set out in the contract were understood.
- all parties should have had read access to contractual documentation in a central location. There should have been a flow of information between the National Programme Team and local organisations to ensure consistency and transparency to support management of contract delivery and supplier relationships.
- although a financial discount had been achieved on the large-scale purchase of licences to use the system, delays in implementing the system mean that the full benefit of that discount has not been achieved to date. This reflects some of my own observations about value for money risks in the contractual framework, which I noted had also needed to evolve over time for various reasons.

The programme assurance review

8 The programme assurance review found that while the overall objective of the original March 2015 business case for WCCIS remained valid – to achieve a shared electronic record across health and social care – it was unclear how the objective would be realised. The review recognised that much of the challenge facing successful delivery of the programme's overall objective was drawn out by my own report in October 2020. The review recommended that the SROs should consider a formal review and 'reset' for the programme.

The Strategic Review

9 The Strategic Review's recommendations, which the programme SROs have accepted and that reflect many of the challenges set out in my report, concerned:

- stabilising the system so that performance and user experience is improved.
- 'descoping' some areas of the current programme such as the work on national data standards and considering transferring responsibility for its delivery to other programmes within Digital Health and Care Wales.
- simplifying the programme by transitioning the operational service management of the system away from the National Programme Team to other DHCW functions.
- 'course correcting' the programme to enable it to focus on its key aim. This will include reviewing contractual and commercial arrangements and updating the business case.
- resetting the programme so that all documentation, ways of working and governance are reviewed and refreshed.
- creating a 'technology road map' that supports standards based inter-operability between WCCIS and other systems within health and social care.
- standardising the approach to the roadmap by signing up to an agreed set out governing design principles so all work has a common objective and design correlates with relevant national digital architectures and standards.
- improving collaboration between stakeholders.

10 A programme of work is now underway to deliver on the recommendations. The programme SROs have also initiated a further programme review process scheduled for November 2022.

Roll out

11 I reported previously that estimated dates from the March 2015 business case, which were also reflected in the original contractual documents, suggested all 22 local authorities and 7 health boards would be using the system by December 2018. At the time of my report, 19 organisations were using WCCIS or had signed deployment orders, with four in active negotiation and six yet to commit. Of the 19 organisations, 13 local authorities and two health boards had gone live.

12 Deployment orders for individual organisations include common elements but can be tailored and with organisations having been able to commission additional functionality beyond that provided for in the original contract. However, even within the common elements, it remains the case that 'live' can means different things as organisations can choose which elements of the available functionality they use and how widely they deploy the system. My report emphasised that the different approaches to implementation mean that it is difficult to realise some of the information sharing and integrated working benefits that the system was expected to support.

13 As of 31 May 2022, a further two local authorities that had signed deployment orders at the time of my report have gone live – Swansea Council and Conwy County Borough Council. We have updated our interactive data tool which provides further detail on the roll-out position across all 29 organisations. However, the Strategic Review highlighted that there are also at least two local authorities that are actively seeking to end their WCCIS contracts.

14 No further health boards have gone live since my report, although Cwm Taf Morgannwg University Health Board signed a deployment order in November 2021. The estimated go-live date now that the deployment order has been signed is yet to be agreed. While not yet live, some health board staff are accessing the system via local authority user licenses. As at the time of my report, the Health Board intends to implement the system in mental health services first.

15 At the time of my report, two health boards had signed deployment orders but were still working towards go live dates.

- Aneurin Bevan University Health Board signed a deployment order in March 2018. The first phase of implementation in mental health services was scheduled for June 2019 but this date was not met. A revised date for mental health services, along with the addition of learning disabilities, was scheduled for November 2021. This date was not met due to ongoing stability issues with the system. A further revised date for mental health services and learning disabilities, which was also expected to include mobile functionality, was scheduled for the end of March 2022. However, this date was also not met. The current target for first phase implementation is August 2022, but this will not include mobile functionality at that point.
- After signing a deployment order in March 2016, Betsi Cadwaladr University Health Board had an initial go-live date of April 2017 for a phased implementation starting with mental health services. The date was not met, and the health board then discussed with the supplier an initial small-scale prototype implementation in its community nursing and therapies teams with a planned start date in November 2021, but this has now been delayed until September 2022.

Costs

The overall picture

16 My report provided an overview of the £30.16 million in central support costs spent or committed through to March 2022. This figure comprised of:

- £8.41 million – capital costs for software development, licenses, hardware and network infrastructure.
- £8.62 million – national programme management support.
- £13.13 million – support for health boards and local authorities for implementation and roll-out and related service transformation.

17 The final outturn figure to March 2022 has remained at around £30 million, but with some changes in the profile of these costs and some of the software development costs rolling forward beyond March 2022. The Welsh Government has also now committed at least a further £8.31 million in total for national programme support (£7.15 million) and support for health board and local authorities (£1.16 million) to accelerate implementation for 2022-23 to 2024-25. The Welsh Government has agreed that this figure may increase to up to £12 million if required.

18 The central support costs figure excluded local implementation costs and service charges met from organisations' own budgets and wider opportunity costs associated with the overall governance arrangements for WCCIS implementation and roll-out. We had been unable to arrive at a reliable overall estimate of local implementation costs met from organisations' own budgets, although it was apparent that these ran into several millions of pounds.

19 To the end of June 2020, those organisations that had progressed with implementation to the point of paying service charges had paid a total of £2.56 million to the system supplier. The overall extent to which this was new expenditure compared with the cost of previous systems was not clear. However, some organisations were realising modest savings compared with the cost of previous systems. By the end of March 2022, overall service charge payments had increased to £4.82 million.

Capital costs

20 My report set out that the capital costs included the Welsh Government's approval, in December 2019 of additional capital grant funding from its Digital Priorities Investment Fund. The Welsh Government allocated £1.0 million for a planned central hardware refresh and £0.8 million for software development. The final cost for the central hardware refresh was £1.93 million, which the Welsh Government met from the Digital Priorities Investment Fund.

21 The £0.8 million approved for software development included £0.47 million to cover development costs within the original scope of the business case and contract. The remainder was for enhancements that were not within the original scope. At the time of my report, the latest estimate of those costs following commercial negotiation was £1.12 million. My report set out the expectation that deploying organisations would need to decide on the affordability and value for

money of the remaining enhancements not covered by the Welsh Government funding.

22 Since my report, the National Programme Team has advised that some of the software requirements from the original scope are no longer needed/or have been overtaken by other developments or cannot be delivered. Work is still ongoing to finalise what the final cost for delivery of the remaining developments costs and additional enhancements will be. The work was due to be completed by end the of March 2022 but will now be incorporated into the programme of work flowing from the Strategic Review.

23 As of February 2022, £0.72 million of the £0.80 million previously approved for software development had been spent, mostly covering enhancements outside of the original contract scope.

24 Due to the additional cost associated with the central hardware refresh, the Welsh Government had committed a total of £9.34 million of capital grant funding to the end of March 2022. While this is still within the original March 2015 business case estimate of £9.89 million, the total costs have not yet been finalised. There is no further Welsh Government capital funding currently planned between 2022-23 and 2024-25.

National programme support costs

25 The £8.62 allocated for national programme management support to March 2022 came from a mix of direct Welsh Government funding and existing budgets for NWIS (and now Digital Health and Care Wales). This figure was around £1.7 million higher than estimated in the March 2015 business case for the same period.

26 Actual reported expenditure to March 2022 was £8.27 million, although as noted above the Welsh Government has committed at least a further £7.15 million for the period 2022-23 to 2024-25.

Support to health boards and local authorities

27 My report set out the sorts of costs organisations might incur to support local implementation including, for example: data cleansing, testing and migration; tablets/laptops to support mobile working; additional/upgraded hardware and software; local support desks and staff costs. My report noted that the March 2015 business case had estimated that these costs would total £2.58 million, compared with the £13.13 million that the Welsh Government had committed at the

time of my report[2] to support local implementation and roll-out and related service transformation[3].

28 In February 2021, the Welsh Government allocated a further £2 million from its Digital Priorities Investment Fund to support local authority implementation during 2021-22. As at March 2022, a total of £12.44 million had been spent by local authorities and health boards. Despite the additional £2 million, this figure has come in below the £13.13 million commitment I reported previously because of an underspend by health boards.

29 As noted above, the Welsh Government has also committed at least a further £1.16 million for health boards and local authorities for the period 2022-23 to 2024-25 for health boards and local authorities.

Outstanding functionality

30 My report highlighted that, under the contract, full system functionality was expected to have been delivered before the end of 2015 but that key aspects of the expected functionality had been significantly delayed. This included certain enhancements to the original contractual requirements. The estimate at the time of my report was that the remaining updates would be delivered on a phased basis through to the end of 2021. Areas where work was still needed included Welsh-language requirements, mobile functionality and interfaces with other NHS Wales systems.

31 A pilot for mobile functionality was scheduled before the end of 2020. Following the publication of my report, the Welsh Government reported to the Public Accounts Committee that the pilot had been delayed by the ongoing impact of the COVID-19 pandemic and would be available by March 2021. However, due to issues with the stability of the system, the pilot was cancelled. There was then a revised plan to rollout mobile functionality as a national product by the end of

---

[2] This included committed funding for health boards to March 2022 but for local authorities only up to March 2021.

[3] My report noted that the National Programme Team had emphasised that the activity that this funding supports extends beyond the scope of the original business case, including wider service transformation work related to WCCIS. The funding has been distributed through Regional Partnership Boards.

February 2022, but this date was also not met. Testing is underway and the plan is now for a staggered release, starting with a pilot phase in Hywel Dda University Health Board and Aneurin Bevan University Health Board in October 2022 before the mobile functionality is made more widely available. The staggered release is intended to help manage the additional load on the system and prevent further performance issues. We now understand that only 11 out of 29 organisations intend to use the mobile functionality when it is available.

32 Some of the required interfaces with other NHS Wales systems were identified in the original scope of the contract, while others were agreed in 2019 as enhancements to the 2015 contract. In October 2020, of the 16 interfaces agreed, only two were live. It was estimated that the remaining interfaces would be delivered on a phased basis by the end of December 2021.

33 The latest position is that 12 of the 14 remaining national interfaces are currently being developed with Aneurin Bevan University Health Board. Some are scheduled for implementation in October 2022 and others by the end of December 2022. Once they have been successfully implemented in the Health Board, they will be available for all other organisations to use. Discussions on timescales for the remaining two interfaces have not yet begun.

34 Some key aspects of the functionality expected to meet Welsh-language requirements set out in the original contract that were not available when I reported also continue to remain unavailable. Currently there is no timescale for when this will be delivered, and it has not been a recent priority for the programme ahead of other issues.

System performance

35 My report outlined that there had been significant ongoing performance issues with the system. Concerns due to system performance issues, including risks to staff and service users, had also been raised in some local reporting by Care Inspectorate Wales and Healthcare Inspectorate Wales.

36 I recommended that the Welsh Government should pull together a clear national picture on feedback from front-line users about the performance and general functionality of the system. In response, the Welsh Government commissioned a user survey, a non-user survey[4] and held a national workshop in June 2021.

37 Although the response rate for the user survey was not as high as the Welsh Government would have liked, it accepted that the findings were broadly representative of the WCCIS user base[5] and recognised there were some serious performance issues that needed to be addressed.

38 Overall, the system was found to be having a more negative, rather than a positive, impact on most users' ability to do their work. For a large proportion of users, the system was not able to support integrated working between health and social care and realise its intended benefits.

39 There were further significant performance and stability problems following planned migration to a new version of the underlying platform for the system, resulting in the system being unavailable altogether for certain periods during October and November 2021. These issues continued to some extent into early 2022 before being resolved in February 2022. We understand that since this time the system has stabilised and there have not been any significant performance issues or outages. The National Programme Team plans regular user surveys as part of future programme engagement work but no dates for this have yet been set.

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[4] The Welsh Government also commissioned a separate non-user survey but received only 20 responses.

[5] 1,252 people completed the user survey based on a total population of 13,803 potential users in May 2021.

Data standards

40 My report highlighted how changes to programme governance structures, including a new national Information Management Board, had been intended to accelerate progress on national data standards which are key to realising some of the benefits of WCCIS. Work on developing national data standards has continued but is still not complete. As noted above, DHCW's contracting lessons learned review, suggested that local authorities and health boards could have agreed a set of common data standards before the contracting tendering process. This may have strengthened support for the programme and incentivised adoption.

41 Recognising the complexity of developing national data standards, the Strategic Review recommended that the data standards work is 'descoped' from the WCCIS programme. Discussions are currently ongoing with Digital Health and Care Wales to decide where this work would best sit.

Benefits realisation and reporting

42 The arrangements for reporting the benefits from WCCIS roll-out have been the subject of discussion and review from the start of the WCCIS programme. At the time of my report, work was still ongoing to develop a suitable reporting framework. This remains the case.

43 As part of the expectations that went with some of its funding support, the Welsh Government was expecting the National Programme Team to produce a comprehensive annual report on the progress of the programme, starting with the period to the end of March 2020. The first report had been due by the end of April 2020, but at the time of writing my report completion was delayed by the impact of COVID-19. To date no annual reports have been produced, although the Welsh Government has been receiving quarterly updates from the National Programme Team. The Welsh Government has now commissioned the consultants who completed the Strategic Review to prepare broader annual reports, but for 2020-21 and 2021-22 only.

44 In November 2021, the National Programme Team finalised a benefits realisation report. The report recognised that to date the organisations that had commissioned WCCIS had done so largely to replace older systems that were reaching their contract end dates. It noted that while this has provided benefits of efficiency in procurement costs and timescales and laid the foundation to enable

integration as other organisations deploy WCCIS, the ‘patchwork’ implementation means that realisation of benefits from integration across service and organisational boundaries has been slower than anticipated. This largely corresponds with the conclusions in my own report.

45 The benefits realisation report made several recommendations. In summary, they included ensuring that the benefits of the programme align with any refreshed vision or purpose for the programme following the Strategic Review. It also recommended that a review and updating of the benefits roadmap, definitions, metrics and baselines be undertaken in the context of the outcomes of the Strategic Review along with the establishment of a Benefits Management Community of Interest.

Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol/
Prif Weithredwr GIG Cymru
Grŵp Iechyd a Gwasanaethau Cymdeithasol

Director General Health and Social Services/
NHS Wales Chief Executive
Health and Social Services Group

Llywodraeth Cymru
Welsh Government

Adrian Crompton
Auditor General for Wales
Audit Wales
24 Cathedral Road
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Our Ref: JP/MR/LC

24 June 2022

Dear Adrian

Audit Wales Report - Tackling the Planned Care Backlog in Wales

Thank you for sharing a copy of your report into tackling the planned care backlog in Wales with me.

You will be aware the Minister for Health and Social Services published our Planned Care Recovery Plan – "Our programme for transforming and modernising planned care in Wales and reducing waiting lists" at the end of April. The plan outlines how we will transform the way services are delivered and reduce waiting times in Wales during the remainder of this Senedd term. The plan also responds to many of the points raised in your report.

I will respond to each of your recommendations in turn.

Recommendation 1: The national plan sets out high level ambitions to reduce waiting times. It includes target milestones to reduce the number of people waiting for treatment but lacks detail on how it will transform planned care. To implement its plan, the Welsh Government should work with health bodies to set appropriately ambitious delivery milestones to measure progress of delivery of the new ways of working set out in the plan.
Accept
Response: The Welsh Government plan - Our programme for transforming and modernising planned care in Wales and reducing waiting lists contains a number of challenging but achievable ambitions, the first of which is to reduce the number of open pathways over 52 weeks for a

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first outpatient appointment to zero by the end of this calendar year.

Andrew Sallows has been appointed as the Director for Planned Care Recovery and is undertaking a baseline assessment for each health board to understand what they need to do to achieve these targets. These plans will contain delivery milestones and Andrew will be ensuring these are achieved.

Recommendation 2:
The Welsh Government should ensure that its national plan is accompanied by a clear funding strategy. This should include identification of the longer-term capital investment that is going to be needed and processes to ensure that revenue funding will support sustainable service transformation.

Accept

Response:
The Welsh Government has made £170 million of additional recurrent funding available specifically for planned care to address the backlog and develop sustainable services.
A further £20m has been allocated to developing sustainable value-based healthcare solutions with £15m allocated to planned care transformation.

Recommendation 3:
The national plan lacks detail on how the Welsh Government will support health boards to ensure they have sufficient workforce capacity to deliver its ambitions. The Welsh Government should work with relevant NHS bodies to develop a workforce plan to build and maintain planned care capacity to support recovery and tackle the waiting list backlog. The plan should be based on a robust assessment of current capacity gaps and realistic plans to fill them.

Accept

Response:
A national workforce plan is being developed and should be completed by the autumn as highlighted in the Recovery Plan.

Recommendation 4:
The national plan includes a new diagnostics board but does not set out the system leadership arrangements needed to drive through the entirety of the plan. The Welsh Government should identify and implement such system leadership arrangements based on ensuring that lessons are learnt from weaknesses in previous national planned care programme board arrangements.

Accept

Response:
A national diagnostic board has been set up, chaired by the Deputy Chief Executive, NHS Wales. This Board has already met.

Lessons learnt from the planned care programme arrangements have been shared with the team establishing the national diagnostic board.

Recommendation 5: The Welsh Government should ensure it has the necessary processes, policy frameworks and programme and performance management arrangements to ensure NHS bodies: a) effectively manage clinical risks and avoidable harms associated with long waits for diagnosis and treatment; b) maintain a focus on the efficient, effective and economical delivery of planned care pathways in line with prudent healthcare principles and which make best use of new technologies; and c) enhance communication with patients to ensure they are informed about how long they can expect to wait, how to manage their condition while waiting, and what to do if their condition worsens or improves.
Accept
Response: a) The Planned Care Recovery Plan is clear that clinical risk must take priority in the management of waiting lists and patient prioritisation. We are committed to reduce long waiting times and will ensure we support those who are waiting. Lengths of waits for both clinically urgent and long waiters will be monitored by the Director for Planned Care Recovery. The need to reduce harm from waits has also been targeted through the agreed milestones in the plan, with an urgency to reduce lengths of waits for outpatients being the first milestone (no open pathway over 52 weeks for a first outpatient appointment by end of December 2022). It is recognised that this is the first clinical opportunity to assess a patient's clinical need since referral and early diagnosis helps to effectively assess risk of harm. b) I am chairing the NHS Wales Utilisation of Resources Group, (this replaces the National Efficiency Group). This group will be looking at efficiency and effective application of prudent and value-based healthcare principles. c) Our planned care recovery plan is clear that we need to improve communication with patients and to support them better whilst they are waiting for their appointments and treatment.

Yours sincerely

Judith Paget CBE

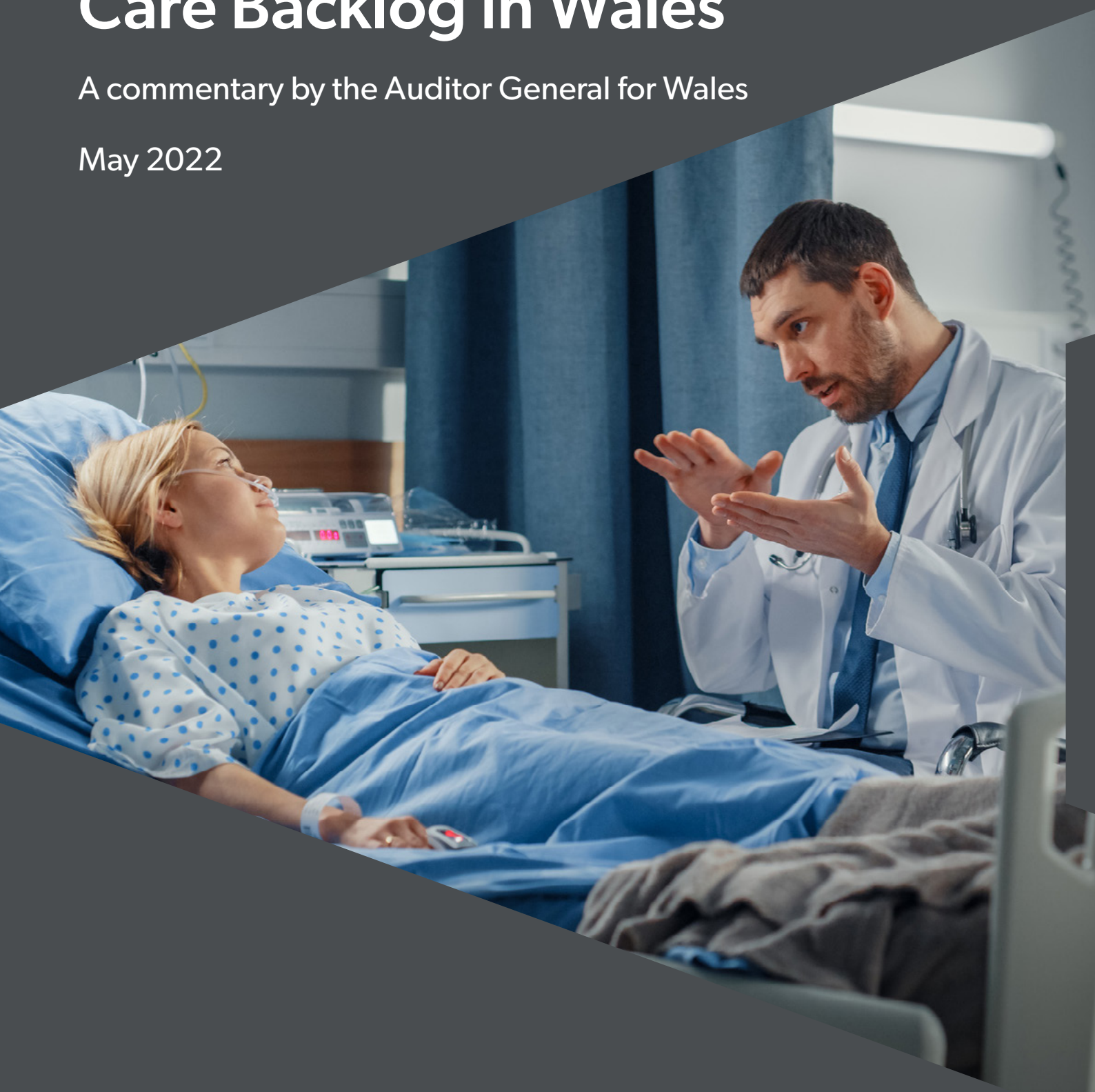
cc: Cabinet mailbox
Mark Isherwood MS, Chair, PAPAC
CGU mailbox

Archwilio Cymru
Audit Wales

Tackling the Planned Care Backlog in Wales

A commentary by the Auditor General for Wales

May 2022



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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

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Summary report

Context

1 The waiting list backlog is one of the biggest challenges facing the NHS in Wales. Waiting times for planned care have long been a problem in Wales. The COVID-19 pandemic and the impact it has had on NHS capacity has made the situation much worse. The number of patients on a waiting list for planned care has grown to a scale never seen before. Tackling that backlog is a herculean task for the NHS. It is also a real worry from the perspective of patients, some of whom are waiting in pain, whose condition is deteriorating and some of whom have now been waiting well over a year just to find out what is wrong with them.

2 This report sets out the main findings from the Auditor General's high-level review of how NHS Wales is tackling the backlog of patients waiting for treatment and responding to the challenges facing planned care. It describes the scale of the backlog of patients waiting for treatment and the wider challenges of delivering planned care. The report also sets out key actions NHS Wales needs to take to tackle the challenges in planned care. This report focuses on services subject to the Welsh Government's referral to treatment target[1].

1 Other services, such as treatment for cancer, are subject to different targets and not covered by this report.

4 Key messages

3 As in other parts of the UK, NHS waiting lists in Wales have grown significantly since the start of the pandemic. In Wales, waiting lists grew by 51% from March 2020 to February 2022 when there were 691,885 patients[2] on a planned care waiting list. 251,647 of these patients had been waiting for more than 36 weeks and 406,743 were still waiting for their first outpatient appointment to discuss their condition and agree a course of action.

4 Although the rate of growth in the overall waiting list has slowed in recent months, there remains a risk that the drop in referrals that was seen during the pandemic has created a hidden or latent demand that will present itself at some point. Compared to pre-pandemic levels we estimate that there are some 550,000[3] 'potentially missing' referrals that could ultimately find their way back into the system.

5 The Welsh Government has made £200 million available during 2021-22 to help tackle the backlog. However, NHS bodies have found it difficult to spend the money. NHS bodies had identified ways to spend £146 million but £12.77 million of that was returned to Welsh Government at the end of March 2022.

6 Whilst additional funding is going to be essential, in and of itself, it will not solve the problem. The NHS needs to increase its activity if it is going to make inroads into the waiting list backlog and there are some significant barriers that need to be overcome in order to do that. These include the on-going impact of COVID on services and staff, a tired workforce with staff shortages, recruitment and retention challenges, limitations in the current NHS estate that can hinder the ability to quickly reshape services, and limited sources of additional capacity such as the private sector.

2 Using the 'open' pathway measure of patients currenting waiting for treatment. Each pathway represents a patient waiting but a patient may have more than one health condition and therefore be on the waiting list more than once.

3 Our figure differs slightly from the 500,000 in the Welsh Government's national plan to transform planned care published in April 2022.

7 The ability to increase planned care activity will also depend on the availability of beds. The number of NHS beds in Wales has fallen steadily over many years. At present the system is also experiencing real difficulties in discharging medically fit patients, due in part to staff and capacity shortages in the social care sector.

8 Our reasonable case scenario modelling has indicated that it could take as much as seven years before waiting list numbers return to pre-pandemic levels. Exactly how long it will take will depend on a range of different factors that are not easy to predict, including the extent to which the latent or hidden demand caused by the pandemic re-appears. And some specialties will take longer than others to return waits to pre-pandemic levels.

9 What is clear is that the NHS will need a stronger focus on doing things differently. Planned care capacity needs to be better protected, and not routinely used as the system ‘safety valve’ and either stopped or reduced when there is increased pressure such as in the winter months.

10 Surveillance of patients whilst they are on the waiting list also needs to be carefully managed to minimise and ideally avoid them coming to harm as a result of long waits for treatment. To help achieve that, performance measures need to have a greater focus on patients’ clinical needs rather than simply how long they have been waiting.

11 A long-term challenge such as the waiting list backlog needs a long-term plan supported by investment. In respect of the latter, the announcement of £185 million additional revenue guaranteed per year over the next four years to support waiting list recovery is significant. It is crucial that this investment is used wisely and that all opportunities to maximise efficiency and modernise services are taken.

12 Whilst the immediate challenge is to tackle the huge backlog that has built up, the ultimate goal must be to create a planned care system that can sustainably balance capacity and demand, something that has been a significant challenge for the NHS in Wales for many years.

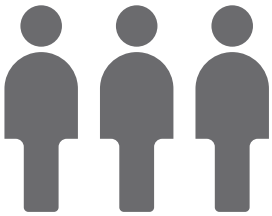
The COVID-19 pandemic will leave the NHS with many enduring legacies not least the significant impact it has had on waiting times for planned care. Just as the NHS rose to the challenge of the pandemic, it will need to rise to the challenge of tackling a waiting list which has grown to huge proportions. Concerted action is going to be needed on many different fronts, and some long-standing challenges will need to be overcome. Additional money has been made available and it is imperative that it is used to best effect to ensure there are equitable and targeted approaches that meet the planned care needs of the people of Wales.

Adrian Crompton
Auditor General for Wales

Key facts

691,885
Total number of people on a waiting list in Wales

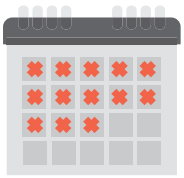
50% increase in total numbers waiting from February 2020 to February 2022



406,743
Number of people waiting for first outpatient appointment

Collectively orthopaedics, general surgery and ophthalmology make up **39%** of the total waiting list

53% of people waiting over **26 weeks** for treatment



56,516
Number of people waiting more than **2 years** (105 weeks) or more

£146.1m
Estimated additional revenue funding allocated to support planned care recovery during 2021/22[1]

£185m
Additional revenue funding made available per year[2]

notes*

Data as of February 2022 unless otherwise stated

1 The Welsh Government made £200m available to support recovery in 2021/22. Of this, only £146.1m was allocated and estimates indicate that of this £12.77m will be returned

2 £170 milion recurring funding plus an additional £15 million per year for the next 4 years.

4 Recommendations

13 In **Exhibit 7** of this report, we highlight a number of key actions that we think are going to be needed as part of the approach to tackle the waiting list backlog. The Welsh Government published its national plan to transform and modernise planned care and reduce waiting times in April 2022[4]. Our recommendations are based around the key actions needed to successfully implement the plan. Whilst they are directed towards the Welsh Government in respect of its system leadership role in setting a framework for planned care recovery, it is recognised that their implementation will, to a large part, be dependent on the plans and activities of individual NHS bodies.

Recommendations

R1 The national plan sets out high level ambitions to reduce waiting times. It includes target milestones to reduce the number of people waiting for treatment but lacks detail on how it will transform planned care. To implement its plan, the Welsh Government should work with health bodies to set appropriately ambitious delivery milestones to measure progress of delivery of the new ways of working set out in the plan.

R2 The Welsh Government should ensure that its national plan is accompanied by a clear funding strategy. This should include identification of the longer-term capital investment that is going to be needed and processes to ensure that revenue funding will support sustainable service transformation.

4 Our programme for transforming and modernising planned care and reducing waiting lists in Wales: Welsh Government, April 2022

Recommendations

R3 The national plan lacks detail on how the Welsh Government will support health boards to ensure they have sufficient workforce capacity to deliver its ambitions. The Welsh Government should work with relevant NHS bodies to develop a workforce plan to build and maintain planned care capacity to support recovery and tackle the waiting list backlog. The plan should be based on a robust assessment of current capacity gaps and realistic plans to fill them.

R4 The national plan includes a new diagnostics board but does not set out the system leadership arrangements needed to drive through the entirety of the plan. The Welsh Government should identify and implement such system leadership arrangements based on ensuring that lessons are learnt from weaknesses in previous national planned care programme board arrangements.

R5 The Welsh Government should ensure it has the necessary processes, policy frameworks and programme and performance management arrangements to ensure NHS bodies:

a effectively manage clinical risks and avoidable harms associated with long waits for diagnosis and treatment;

b maintain a focus on the efficient, effective and economical delivery of planned care pathways in line with prudent healthcare principles and which make best use of new technologies; and

c enhance communication with patients to ensure they are informed about how long they can expect to wait, how to manage their condition while waiting, and what to do if their condition worsens or improves.

What is the scale of the challenge?

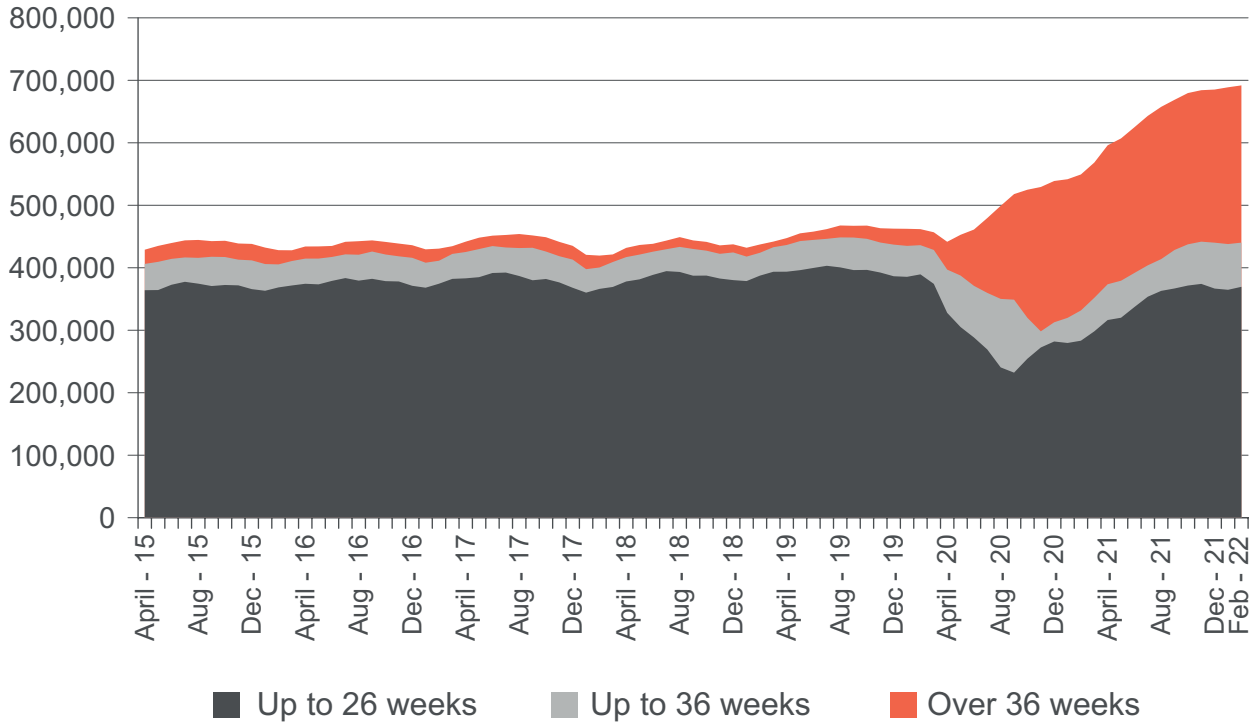
The numbers of people waiting for planned care, and the length of time they are waiting has increased significantly

1.1 The impact of the pandemic on planned care waiting times is clear. There was an immediate increase in the numbers of people waiting from April 2020, and numbers have continued to rise.

1.2 In February 2022, there were 691,885 patients waiting on the referral to treatment list (**Exhibit 1**). Of those 251,647 (36%) had been waiting more than 36 weeks. 406,743 patients (59% of all those waiting) were waiting for their first outpatient appointment to discuss their condition and agree a course of treatment. Of those, 146,198 (36%) had been waiting more than 36 weeks for their first outpatient appointment.

1.3 Since the beginning of the pandemic, the total number of people waiting for a diagnostic test increased from around 110,000 to nearly 165,000 in February 2022. Typically, during 2018-19 and 2019-20 there were around 15,000 diagnostic waits over eight weeks, but this rose to over 74,000 in January 2022. February 2022 figures showed some improvement with just over 66,000 waiting over eight weeks.

Exhibit 1: number of people waiting for planned care April 2015 – February 2022



Source: Audit Wales analysis of Welsh Government data

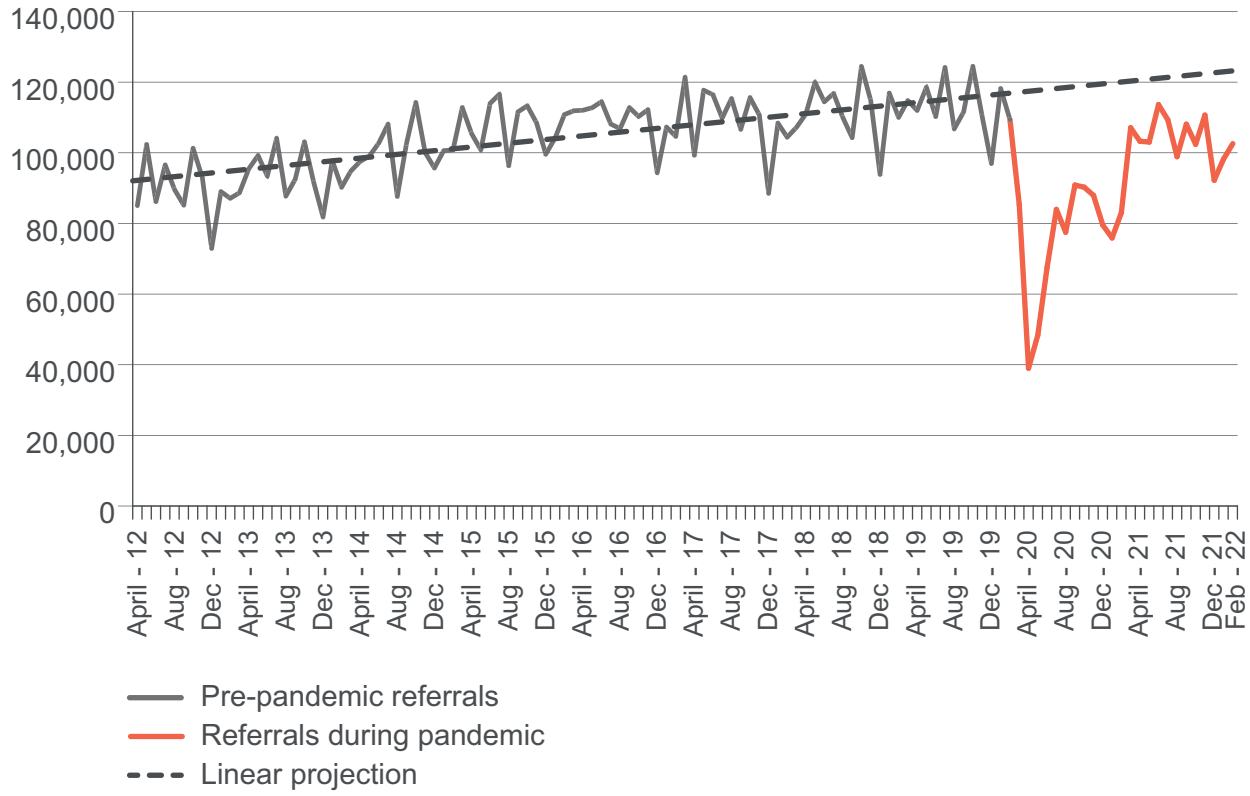
1.4 There is variation in the length of time patients wait for treatment depending on where they live. For instance, November 2021 figures show that people living in the Hywel Dda University and Powys Teaching Health Board areas were least likely to have waited over 36 weeks whilst residents of Betsi Cadwaladr and Cwm Taf Morgannwg University Health Board areas were the most likely to have experienced such waits.

1.5 The Senedd Health and Social Care Committee held an inquiry into the impact of the waiting times backlog. Responses[5] to the Committee's consultation on waiting times demonstrate the serious impact of long waits on different patients. Patient representatives also raised concerns with us about the impact on patients. Along with some health board officials, they told us that by the time some patients are treated, their conditions have worsened and that for some patients the deterioration has been significant enough for them to present at emergency departments.

5 Health and Social Care Committee, **Inquiry into the Impact of Waiting Times Backlog on People Waiting for Diagnosis or Treatment**, November 2021 – March 2022.

1.6 The direct and indirect impact of COVID-19 may increase the quantity and complexity of demand for planned care. **Exhibit 2** shows that whilst referrals for a first outpatient appointment have increased steadily for years, they fell dramatically at the start of the pandemic and have not fully returned to pre pandemic levels. Our analysis suggests that the total reduction in referrals equates to around 550,000 'potentially missing' patients when comparing referrals from March 2020 to February 2022 data against the 2019-20 referral averages. Our calculation of 'missing' patients is a conservative estimate. There may also be additional new demand both from the direct impact of COVID-19, and the indirect impacts of the pandemic on citizens' health and well-being.

Exhibit 2: referrals for a first outpatient appointment April 2012- February 2022



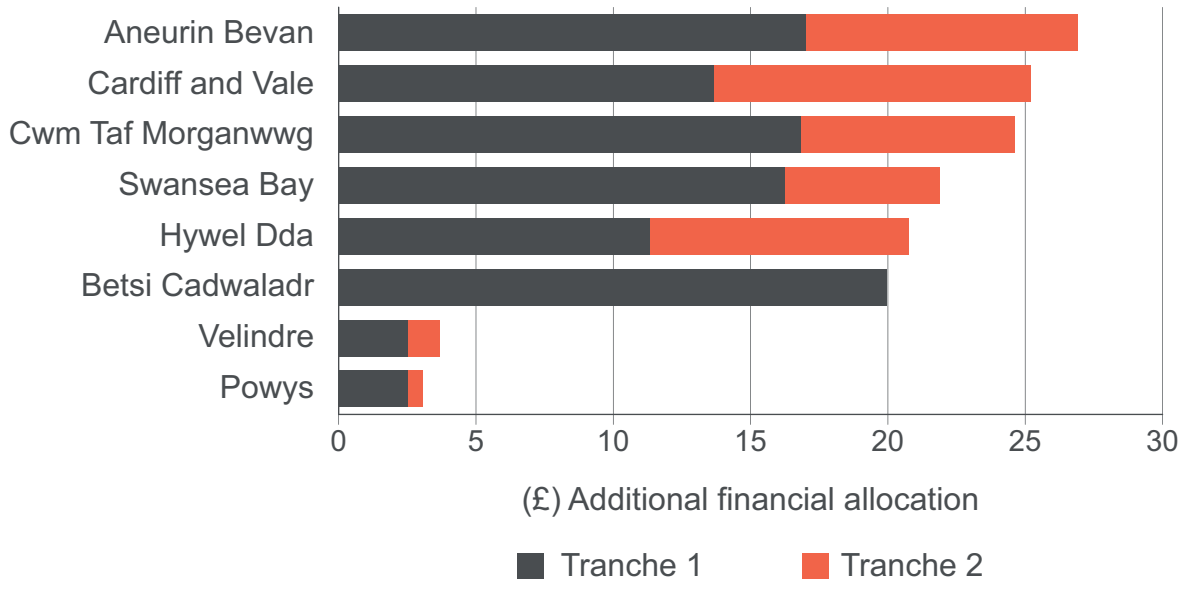
Source: Audit Wales analysis of Welsh Government data

There are significant factors restricting planned care activity

NHS bodies are struggling to spend all of the Welsh Government's funding for planned care

1.7 The Welsh Government made two announcements for additional funding to support recovery, with a combined value of £200 million in 2021-22[6]. At the time of writing this report, the Welsh Government had allocated £146.1 million of the £200 million indicating that NHS bodies have found it difficult to identify and spend on costed recovery programmes in the short term. The £146.1 million funding was provided in two tranches and **Exhibit 3** shows these individual allocations. The allocations have been based on bids from NHS bodies into the Welsh Government. The first tranche generally follows a population-based allocation, the second is based on the ability of NHS bodies to productively utilise the funding to support improvement.

Exhibit 3: 2021-22 financial allocations to support health and care recovery



Source: Audit Wales of Welsh Government data

6 Announcement of additional allocation 20 May 2021 and Announcement of additional Welsh Government allocation, 19 August 2021

1.8 Health boards also told us that spending the money has been more difficult than expected and some have been unable to spend all of it[7]. Estimates indicate that £12.77 million will be returned. Health boards have looked to secure additional planned care capacity by outsourcing some activity and insourcing staff resources where possible. The private healthcare sector in Wales is small and in part relies on NHS consultants seeing private patients in their own time. Welsh health boards are competing with NHS England to secure private capacity from across the border. As a result, health boards told us it was difficult to find enough additional capacity and where they had contracts with private providers, delivery often fell short of the number of patients agreed at the outset.

1.9 Some health boards said that they lacked suitable physical space to conduct additional planned care activity in accordance with infection prevention and control measures. Modifications to existing hospital estates are likely to require capital funding but constraints on the amount of capital funding that is available was cited by some as a further impediment.

1.10 A longer-term approach to funding can assist with plans to address the backlog. The Welsh Government is providing more certainty over future funding by guaranteeing an additional recurring £170 million annual funding for planned care for three years from 2022-23. On top of the recurring funding, the Welsh Government announced an additional £15 million annual funding up to 2025-26 to support delivery of its national plan.

1.11 Whilst the additional £146.1 million allocation in 2021/22 did not result in an overall reduction of waiting lists, it has appeared to help reduce the rate at which the waiting list has grown.

7 As of March 2022, NHS bodies had returned just over £12.77 million of the recovery funding for tranches 1 and 2.

The NHS Wales workforce is tired, stretched thinly and under pressure

1.12 Health board officials told us that staff capacity was their biggest challenge in delivering planned care. Our Picture of Healthcare report explains that the NHS Wales workforce has increased in recent years but there are specific and long-standing shortages in some areas, such as anaesthetists, radiologists and nurses. The pandemic has left a legacy of a tired workforce with increased rates of sickness absence. There are also concerns that more staff are leaving or retiring early due to the pandemic. Recruitment challenges also persist with NHS bodies competing in a small pool for medical staff and for the first time, several are reporting shortages of administrative staff to book and schedule clinic and theatre time.

Curtailing planned care remains the default position when there is increased emergency care demand in the system

1.13 The cessation of planned care at the start of the pandemic was necessary given the circumstances but it also reflected a default NHS response to pressure on the system. Cancelling or curtailing planned NHS care has long been used as the system 'safety valve' when emergency demand is high such as during the winter months. In the past, health boards have planned their elective activity around likely peaks in emergency care, attempting to catch-up during quieter periods. The Welsh Government is currently updating its escalation framework setting out how health bodies should respond to differing levels of emergency pressure. The current situation is different. Urgent and emergency care pressure on the NHS is likely to remain high for some time as a result of dealing with on-going COVID related illness and patients who had not sought help earlier in the pandemic who are now presenting with more serious symptoms. It may be unrealistic to wholly protect planned care capacity from emergency care pressures, but if the current imbalance continues, Wales will see large waiting lists and long waits for many years.

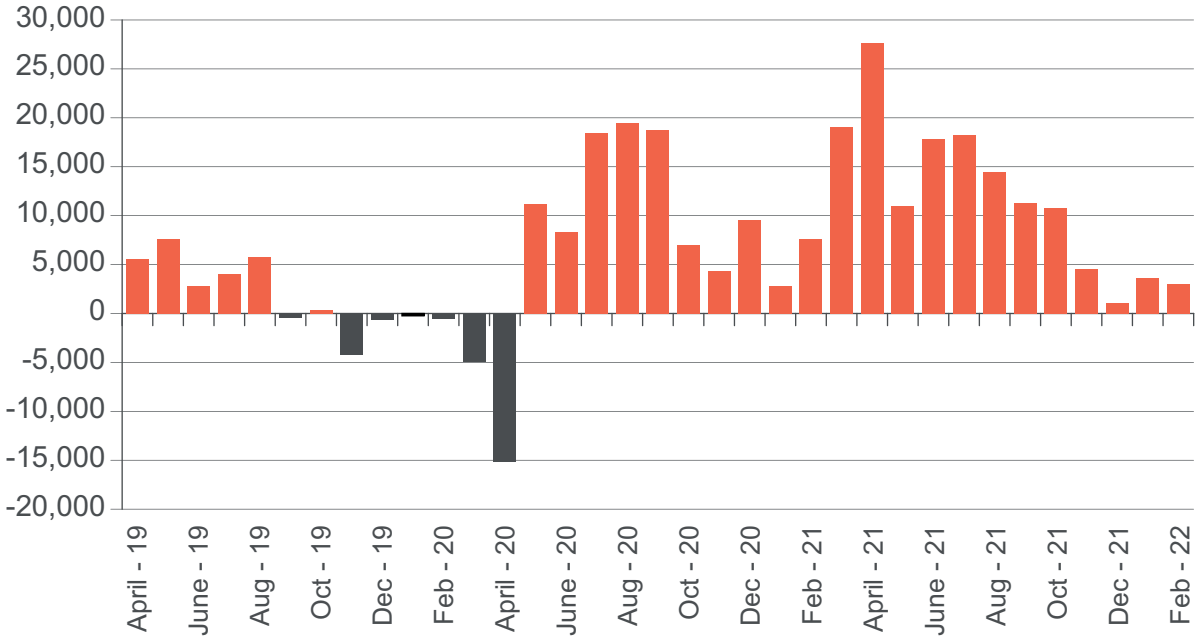
Medically fit patients are occupying NHS beds

1.14 As set out in Our Picture of Healthcare report, NHS bed numbers in Wales steadily decreased in the years before the pandemic from around 12,100 in 2010-11 to around 10,300 in 2020-21. Several health boards are finding it difficult to discharge patients effectively to free up beds for new patients. Some health boards told us that they can have several hundred medically fit patients occupying hospital beds at any one point in time. These patients are typically waiting for social care packages, either to support them living in their home, or in a care home whilst others are waiting for access to other health professionals such as physiotherapists before they can leave hospital.

Tackling the backlog of patients waiting for treatment could take years

1.15 **Exhibit 4** shows the month on month increase or decrease of the waiting list between April 2019 and February 2022 and demonstrates how the number of patients on waiting list has grown each month since the start of the pandemic. It also shows that since July 2021, the rate of waiting list growth is generally decreasing.

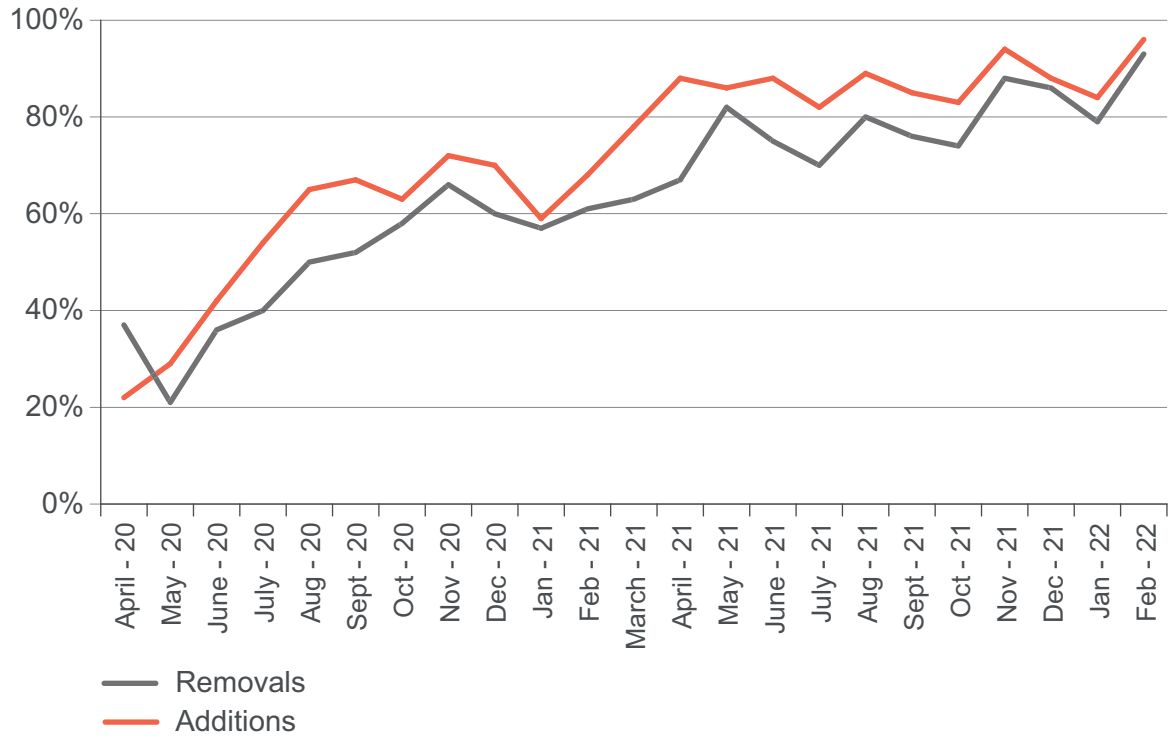
Exhibit 4: all Wales – month on month growth (orange) or decline (grey) in the numbers of people on the waiting list



Source: Audit Wales analysis of Welsh Government data

1.16 The slow-down in growth of the waiting list reflects the fact that the number of people removed from the waiting list has been gradually increasing. **Exhibit 5** shows that over the autumn and early winter of 2021, the gap between the number of people added to the waiting list (additions) and the number of removals (either through treatment or because they no longer needed treatment) shrunk. A continuation of this trend such that removals exceed additions will be needed to start to bite into the waiting list backlog.

Exhibit 5: estimated additions and removals from the waiting list compared to 2019-20



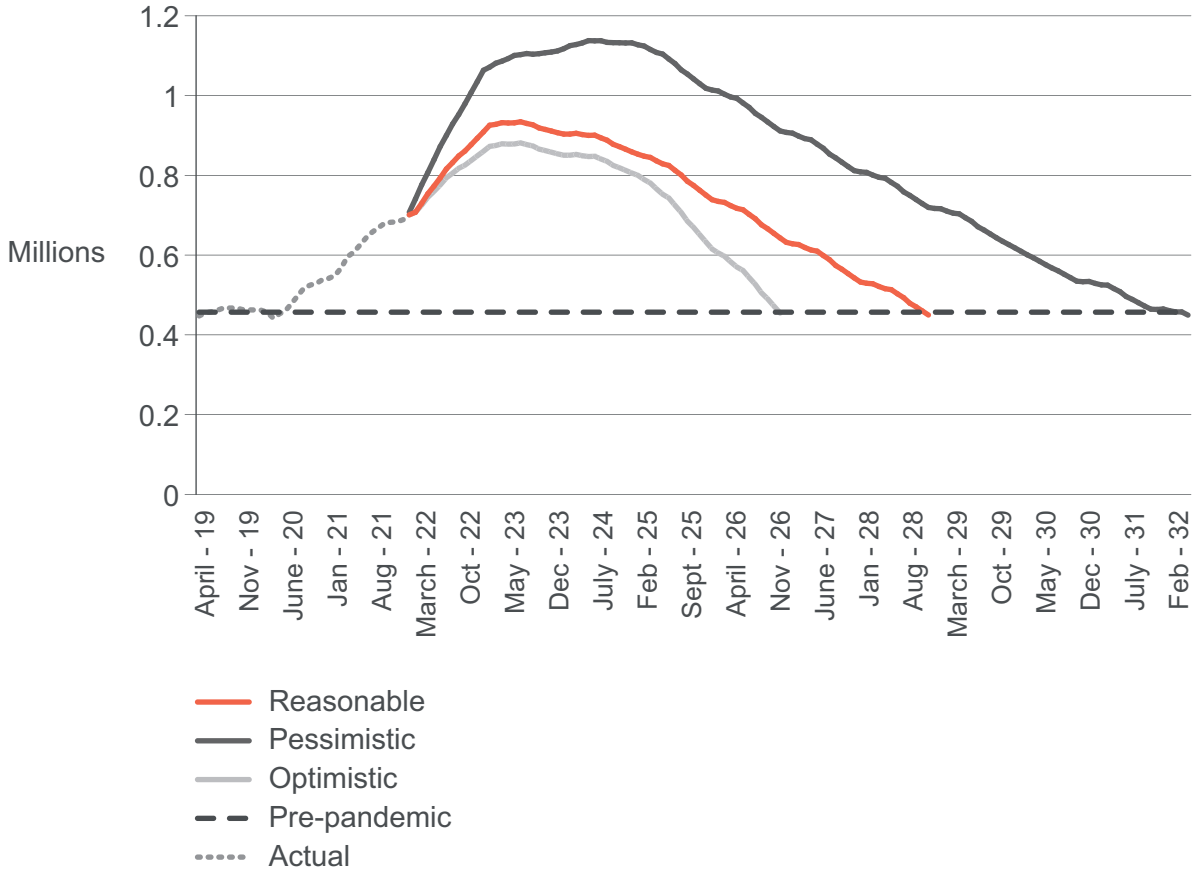
Note: More detail on how we calculated additions and removals from the waiting list is provided in **Appendix 1**.

Source: Audit Wales analysis of StatsWales data

1.17 We have used Welsh Government data to work out how long it could take NHS Wales to get waiting lists back to March 2020 levels[8]. We developed three illustrative scenarios: reasonable, pessimistic and optimistic. The modelling (**Exhibit 6**) for our reasonable scenario suggests that the waiting list could peak in 2023 but return to pre-pandemic levels by 2029. In our optimistic scenario the return to pre-pandemic levels shifts forwards to 2027 whereas in our pessimistic scenario, the waiting list would remain above pre-pandemic levels until 2032.

8 Appendix 1 sets out how we modelled the scenarios.

Exhibit 6: illustrative scenarios of waiting list numbers



Source: Audit Wales analysis of StatsWales data

1.18 The key variables in our modelling cover the rate at which people are added to the waiting list over time and the extent to which the potentially 'missing' patients or latent demand returns. Our modelling does not consider possible new or more complex demand as a result of population health trends or the impact of COVID-19. It also makes different assumptions about the rate at which the NHS is able to remove people from the list. The ability to remove patients is determined largely by capacity and will be influenced by several factors, especially in the short-term:

- the prevalence of COVID-19 in the community significantly reducing, with a resulting drop in COVID related hospitalisations;
- possible relaxation of COVID-19 infection control measures in hospital
- workforce capacity increasing; and
- the extent that additional funding made available over the next three years is able to be used to best effect.

1.19 The model above is illustrative and covers the whole waiting list. It is acknowledged that each planned care specialty is different and will have differing rates of demand and capacity. Specialities such as Ophthalmology and Orthopaedics, for example could take far longer to recover than others because these specialities were stretched before the pandemic. Equally, other specialties may be able to move more quickly.

4 What does NHS Wales need to do to tackle the challenges in planned care?

1.20 From our discussions with both NHS bodies and the Welsh Government, it is clear that tackling the planned care backlog is a key priority. Investment has been identified, plans are being developed and evidence of early progress in some areas is starting to emerge.

1.21 However, the scale of the challenge is huge and it will require the NHS to transform at a scale and pace not seen before. The national plan which has been produced will need to be accompanied by clinical and managerial leadership across the whole system that is aligned to a common purpose.

1.22 A renewed focus on driving as much efficiency as possible out of existing resources is going be essential. But this by itself won't be enough, and additional capacity will need to be identified to initially tackle the backlog and then balance demand and capacity in a way which has not been done previously.

1.23 In a context of many patients having to wait a very long time for their treatment, the NHS will need to ensure that it has the necessary prioritisation and review mechanisms to identify those patients who need to be seen more urgently to minimise avoidable harm. There also needs to be an enhanced approach to communicating with patients while they wait to help them manage their condition and know what to do if their condition gets worse.

1.24 These key actions are explored further in the graphic below.

Exhibit 7: key actions for NHS Wales to tackle the challenges in planned care

Clear national vision and supporting investment	The Welsh Government's plan to transform and modernise planned care and reduce the backlog should be supported by frameworks with ambitious goals and milestones to recover and transform planned care. The plan should be informed by a realistic assessment of the capacity that is likely to be available to achieve these. It must be supported by an investment strategy which includes a more strategic and longer-term approach to capital funding to facilitate the required changes to NHS estates needed for planned care recovery.
Strong and aligned system leadership	A system is needed that translates national vision into local action, recognising that the previous national programme board arrangements had limited success. Clinical and managerial leadership within organisations needs to be aligned around a common purpose and lessons learnt from how the NHS and its partners responded to COVID need to be transferred to help tackle the longer term planned care challenges.
Renewed focus on system efficiencies	Using existing resources to best effect should be a key priority. This will mean doing things differently by improving existing processes and systems. It will also mean doing different things and rethinking how, where and from whom patients get the advice and treatment they need. Constraints associated with infection prevention and control will need to be factored in but a focus on prudent healthcare principles and key efficiency measures should be maintained. Opportunities to make best use of new digital technologies need to be secured and ways of speeding up diagnostic tests explored.

Build and protect planned care capacity

Additional capacity is undoubtedly going to be needed in the short term and clear plans are going to be needed to identify where this is going to come from. The extent to which planned care capacity can be protected from emergency care pressures should also form part of national and local planning. The Welsh Government frameworks should support health boards to prioritise emergency care at times of great pressure but must also help them to balance the needs of patients waiting for planned care. Some health boards have made progress in creating dedicated facilities for elective work which have seen some success. Whilst it may not always be practical or the best use of resources to physically separate facilities, the system does needs to think differently about how it protects planned care. A more collective approach to capacity planning across health board boundaries is going be needed alongside a critical review of the number of staffed beds required in the system. This will also include a need for effective workforce planning at local, regional, and national levels.

Manage clinical risks and avoidable harms

Management of the planned care system will need to shift to one that is based on the clinical need of patients rather than how long they have been waiting. Performance monitoring should be based around recommended lengths of waits for different categories of clinical priority with a focus maintained on minimising the extent to which patients' conditions deteriorate whilst they are waiting. There needs to be a particular focus on monitoring the condition of patients who face long waits for their first outpatient appointment. The role that general practice can play in prioritising and managing patients waiting for treatment also needs to be considered.

Enhanced communication with patients

Building on existing mechanisms, NHS bodies will need to ensure they are communicating effectively with patients about the likely time they will need to wait, how to manage their condition whilst they wait and what to do if their condition worsens or improves. Given the numbers of patients waiting, NHS bodies will need to ensure that they are investing sufficient resources into patient information and communication.

Appendix

1 Our approach

1 Our approach

The evidence base for our work comes from reviews of documents and metrics on planned care, and interviews with health board and Welsh Government officials and patient representatives. Our data analysis is based on Welsh Government data on StatsWales.

Our scenario modelling in **Exhibit 6** draws on some initial modelling work carried out by the NHS Delivery Unit. The calculation we used, following the work of the Delivery Unit was:

- removals are calculated by taking the number of patients waiting over 4 weeks (ie, they are not new patients that month) and subtracting that from the total waiting list in the previous month. This gives a proxy for the numbers of patients removed from one month to the next.
- additions are the people reported in the monthly figures who have been waiting less than 4 weeks – indicating they have been added to the waiting list in the last month. Whilst monthly additions give a reasonable measure of additions, some of those included may have already been waiting but had their 'clock' reset for some reason, for example not turning up for multiple appointments. It is also possible that some people may not be counted if they were added and removed before the data was captured at the end of each month.

Our modelling provides scenarios for the length of time it could take NHS Wales to bring waiting lists back to March 2020 levels using three scenarios: reasonable, pessimistic and optimistic (**Exhibit 6**). We accounted for the possible pent-up demand (**see paragraph 1.6**) by evenly spreading differing proportions of the potential missing 550,000 referrals over 2022-23. Those proportions varied depending on an optimistic, reasonable or pessimistic scenario. **Exhibit 8** sets out our modelling assumptions.

Exhibit 8: waiting list modelling assumptions

Assumptions	Reasonable	Pessimistic	Optimistic
Additions 2022-2025 compared to 2019-20	100%	100%	100%
Annual increase in additions 2025 onwards	0.5%	0.5%	0%
Latent 'missing' referral demand presenting	40%	50%	30%
Activity/removals compared to 2019-20 levels during:			
2022-23	101%	95%	101%
2023-24	103%	95%	103%
2024-25	105%	100%	105%
2025 onwards	110%	110%	115%

Our analysis highlights the scale of the possible challenge and the length of time it could take to clear the backlog of people waiting for treatment. The scenarios we have presented in the report are based on assumptions which may alter over the coming years.

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